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University of California
Berkeley, California

Robert Gumbiner, M.D.

FHP: THE EVOLUTION OF A MANAGED CARE HEALTH MAINTENANCE ORGANIZATION, 1993-1997
VOLUME II

Includes Interviews with:
Nick Franklin
Burke F. Gumbiner

Interviews Conducted by
Sally Smith Hughes
in 1996

Since 1954 the Regional Oral History Office has been interviewing leading participants in or well-placed witnesses to major events in the development of Northern California, the West, and the Nation. Oral history is a method of collecting historical information through tape-recorded interviews between a narrator with firsthand knowledge of historically significant events and a well-informed interviewer, with the goal of preserving substantive additions to the historical record. The tape recording is transcribed, lightly edited for continuity and clarity, and reviewed by the interviewee. The corrected manuscript is indexed, bound with photographs and illustrative materials, and placed in The Bancroft Library at the University of California, Berkeley, and in other research collections for scholarly use. Because it is primary material, oral history is not intended to present the final, verified, or complete narrative of events. It is a spoken account, offered by the interviewee in response to questioning, and as such it is reflective, partisan, deeply involved, and irreplaceable.

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It is recommended that this oral history be cited as follows:

Robert Gumbiner, M.D., "FHP: The Evolution of a Managed Care Health Maintenance Organization, 1993-1997, Volume II" an oral history conducted in 1996 by Sally Smith Hughes, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1997.

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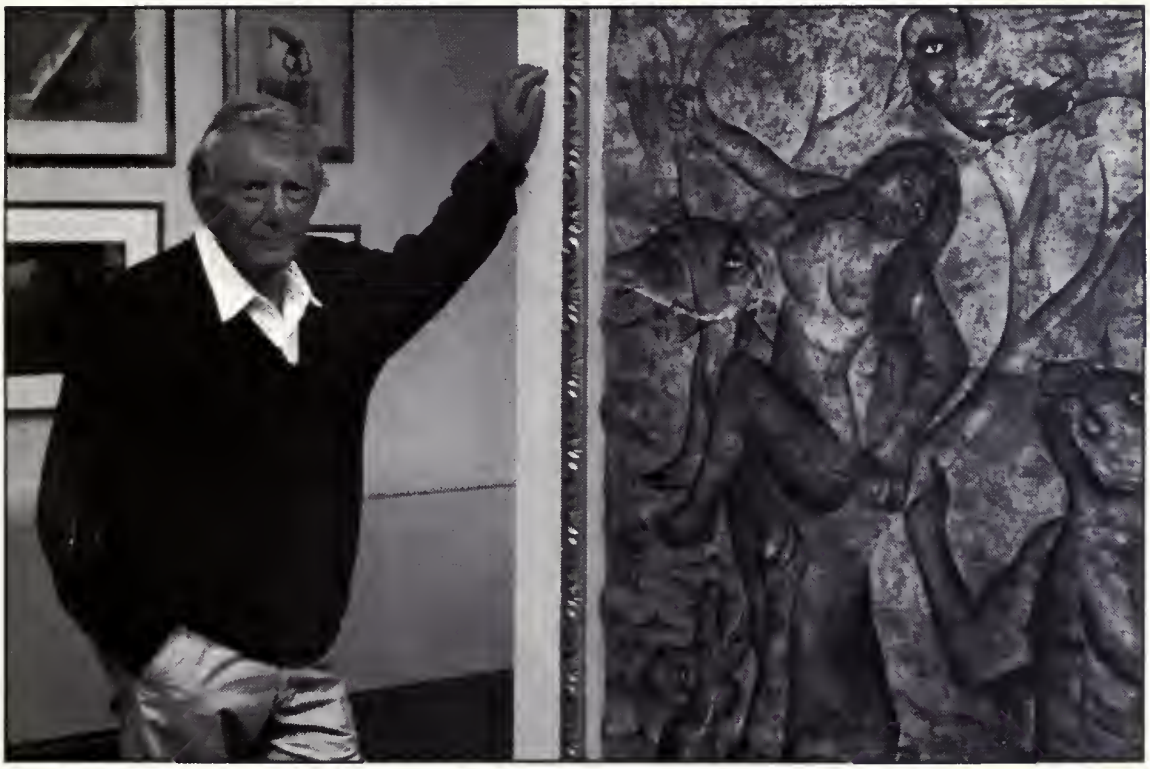

Robert Gumbiner, M.D., in his private gallery, with The Dream, 1990 by Cecilio Sanchez.

Cataloging information

GUMBINER, Robert (b. 1923) Physician-HMO Founder

FHP: The Evolution of a Managed Care Health Maintenance Organization, 1993-1997, Volume II, v, 170 pp.

Views on current health care industry; FHP federal and state lobbying efforts, management; FHP/TakeCare merger; Gumbiner's resignation as FHP board chairman; FHP restructuring, chairman/board relationships; demise of FHP IPA [independent practice assocation]/staff model structure; art, restaurant, and philanthropic endeavors. Includes interviews with **Nick Franklin**, senior vice president of FHP Public Affairs; and **Burke Gumbiner**, FHP senior vice president and president of FHP insurance group.

Interviewed in 1996 by Sally Smith Hughes.

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INTERVIEW HISTORY--by Sally Smith Hughes, Ph.D.

In July 1996, two years after completion of his oral history,[1] Robert Gumbiner wrote me regarding a project to create an oral history "addendum". As he put it:

> The recent dramatic events within FHP which involved a back-door takeover by the Company [TakeCare] that we [FHP] recently purchased for a premium and the betrayal of the long term Company objectives as followed for 30 years by certain Board members would be an interesting follow-up to the Oral History.[2]

The request represented an opportunity to update the previous history of FHP, a major health maintenance organization headquartered in southern California, and also to record an example of recent trends towards consolidation and managed care in the health care field. I agreed to Dr. Gumbiner's "addendum" if the interviews were placed in the context of current changes in the HMO industry and if I could conduct short interviews with others related to the developments he wished to recount. My goal with the first request was to relate recent FHP history to the larger scene in managed care. The second request was aimed at broadening the perspective on events in which Gumbiner was a central and far-from-objective participant. I explained: "It is to your advantage and mine to produce an account that is academically credible and widely useful."[3]

Dr. Gumbiner agreed to both requests. However, the first proved easier to execute than the second. The oral history opens with Gumbiner's views on recent changes in health care policy, interlaced with references to FHP and TakeCare, the company which FHP acquired in June 1994. In relation to my second request, Gumbiner suggested the following people to contact for short interviews: Jack Anderson, Anna Marie Dunlap, Nick Franklin, Burke Gumbiner, Warner Heineman, Robert Murphy, Christine Peterson, Joe Prevratil, W. W. Price, III, Richard Rodnick, and Ryan Trimble. All, except his son Burke, president of the FHP Insurance

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[1]Robert Gumbiner, FHP: The Evolution of a Managed Care Health Maintenance Organization, 1955-1992, Regional Oral History Office, University of California, 1994. The oral history is also available as a published book of the same title, but missing two short interviews (with Charles A. Lifschultz and Jack D. Massimino) originally appearing with the oral history.

[2] Robert Gumbiner to Sally Hughes, July 27, 1995.

[3] Sally Hughes to Robert Gumbiner, August 21, 1995.

Division, and Nick Franklin, corporate lawyer and legislative advocate at FHP, directly or indirectly[1] refused an interview.

After discussing the refusals, Dr. Gumbiner supplied additional suggestions for interviews[2] and offered to contact them by telephone to explain the project: Gary Goldstein, Judd Jessup, and a second try for Bill Price. Once more, I issued written invitations and was again met with failure, this time total. Recognizing that other factors may also be involved, this reluctance to talk on record nonetheless provides some measure of the charged atmosphere surrounding recent changes in FHP's direction.

Oral history is an intrinsically and deliberately subjective methodology, providing one individual's (the interviewee's) view of events in which he or she has participated or witnessed directly. Although balanced against written documents and, where possible, other oral history accounts, it makes no pretense at objectivity, (if there is such a thing). This oral history is no different from any other in its reflection of the narrator's personal viewpoint. Perhaps in this volume there is merely a difference of degree. Widely known as a strong and colorful personality, Gumbiner as reflected in the interviews is strong and colorful. And at times bitter--bitter for what he sees as TakeCare's destruction of his vision of FHP as a provider of quality health care at an affordable price. Evolving over the years since its foundation in the early 1960s through all the major models of health care delivery in the U.S.,[3] FHP had arrived at a combination of staff model and IPA [Independent Practice Association] which Gumbiner felt appropriate for the present health care scene.

His critics, most significantly the executives of TakeCare, disagreed. Expressed simplistically, they and others felt that many health services should be "outsourced", that is, provided by companies with which FHP contracted for services. Gumbiner's disagreement with this philosophy and disillusionment over the events following FHP's acquisition of TakeCare are the subject of this frank and revealing oral history.

INTERVIEW PROCESS

Three short interviews were conducted with Dr. Gumbiner in his new home in Long Beach, which he shares with Judy Parsons, whom he married recently. I stayed in the guest house on the adjoining property which is also the site

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[1] Individuals either failed to respond to written requests, explicitly declined participation, or, after initial arrangements for a date and time for a telephone interview, were found on multiple attempts to be unavailable.

[2] Robert Gumbiner to Sally Hughes, July 17, 1996.

[3] See the first oral history.

of the art gallery housing Gumbiner's collection of Micronesian and Mexican art. The site of the interviews was Gumbiner's office on the top floor of a building which includes his home and personal office space, including a suite for two private secretaries. We sat in a spectacular semicircular room surrounded by sculpture and artifacts and luminous views of the yacht harbor.

Still suffering from the after-effects of surgery performed on two occasions early in 1995, Gumbiner sometimes arose to pace in pain, and on another occasion curtailed the interview to consult his physician. The reader will be left to judge what effect the pain, perhaps psychological as well as physical, had on his view of history.

At Dr. Gumbiner's suggestion, Karen Rasmussen and Karen Simmons, Dr. Gumbiner's assistants, transcribed his interviews. Dr. Gumbiner edited them, and I reviewed the corrected transcripts, making some insignificant editorial changes. I decided to let repetitions stand, since to remove them would have disrupted the narrative flow and attenuated the impact of Dr. Gumbiner's insistent return to certain themes: "death of a [his] dream" for FHP, utility of a combined staff and IPA model, disillusionment with health care as a market-driven economy, and so on. Dr. Gumbiner suggested and supplied the material for the appendices. The interviews with Burke Gumbiner and Nick Franklin were transcribed and edited at the Regional Oral History Office and sent to the interviewees for review and approval.

This volume is testimony to the value--and pitfalls--of oral history conducted "in the heat of the battle". Memories and emotions, only just formed, are fresh and vivid. Accounts such as this lack the "distance" and "synchesis" characterizing most historical writing. Hence conclusions are more than ever the reader's responsibility. The difficulty is compounded when the topic, as in this case, is the rapidly changing field of health care. The reader must judge the pluses and minuses of this variety of oral history. At the very least, she is in for an exciting account of an episode which could be taken as emblematic of the turmoil and constriction of the current health care scene.

The Regional Oral History Office was established in 1954 to augment through tape-recorded memoirs the Library's materials on the history of California and the West. Copies of all interviews are available for research use in The Bancroft Library and in the UCLA Department of Special Collections. The office is under the direction of Willa K. Baum, and is an administrative division of The Bancroft Library of the University of California, Berkeley.

Sally Smith Hughes, PhD
Senior Interviewer/Editor

Regional Oral History Office
November 1996

February 21, 1997: Not surprisingly, history did not pause while this volume was being produced. In the final stages of processing, PacifiCare began its acquisition of FHP, which state regulators approved on February 14, 1997. To chronicle the newest acquisition, Dr. Gumbiner wrote an addendum, which has been included, as he sent it, at the end of the oral history. --S. S. Hughes

Regional Oral History Office
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Berkeley, California 94720

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name [illegible]

Date of birth 1-31-23 Birthplace St. Louis, Mo

Father's full name [illegible]

Occupation Physician Birthplace [illegible]

Mother's full name Anna [illegible]

Occupation [illegible] Birthplace [illegible]

Your spouse Judy

Occupation [illegible] Birthplace [illegible]

Your children [illegible]

Where did you grow up? [illegible]

Present community [illegible]

Education [illegible] University

Occupation(s) Physician

Areas of expertise [illegible]

Other interests or activities [illegible]

Organizations in which you are active [illegible]
CSUCB [illegible]

I THE HEALTH CARE INDUSTRY AND FHP: BACKGROUND INFORMATION

[Interview 1: February 12, 1996] ##[1]

The State of the U.S. Health Care Field

Hughes: The health field has changed rather remarkably in the three years since your first oral history.[2] I wondered if you would care to start with your feelings about what is happening in terms of managed care, and how the [President William J.] Clinton administration policies enter in?

Gumbiner: While you were talking, I was thinking, What changes have happened? First, there have been consolidations of health provider organizations as they attempt to position themselves to be large enough to take care of larger entities and larger problems. In the last three years, we've had the Clinton administration's attempt to reconstitute the health care delivery system in order to stop the ever-spiraling upward cost of health care.

Everybody now realizes that the effort was a disaster. It was too complicated, took too long, and allowed the entrenched organizations to get ready to destroy it. This was mainly the Health Insurance Association of America, which mounted probably one of the most effective and confusing advertising campaigns in history. They worked on the theory that, if you can't defeat them, confuse them. So the American public became so confused that, although most of them want something done about rising

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[1]## This symbol indicates that a tape has begun or ended. A guide to the tapes follows the transcript.

[2]Robert Gumbiner, M.D., "FHP: The Evolution of a Managed Care Health Maintenance Organization, 1955-1992," Regional Oral History Office, University of California, Berkeley, 1994. Hereafter, Gumbiner oral history I.

health care costs and the disorganized way it is being delivered, they couldn't figure out the administration's plan.

I was on the side of just expanding Medicare to take in pregnant women and children and lower the Medicare eligible age to fifty-five; then we could slowly and incrementally include the entire population. We have had Medicare for almost twenty-four or twenty-five years now, and had a chance to shake out a lot of problems.

At the same time, we have had quite a Republican congressional revolution during the last year. Approximately a year ago, the Republican right wing got control of both the [U.S.] Senate and the [U.S.] House [of Representatives]. The House began working to get rid of the so-called social safety net. I don't think they have gotten any place because we now see they can't really do anything to Medicare, and it's now a budget standoff. This really is a standoff in philosophy between Clinton--his administration wants to preserve the safety nets of Medicare and Medicaid--and the Republican House, with Speaker Newt Gingrich, who wants to diminish them.

Again, we have a confusing situation where the House claims that they are not diminishing benefits and the administration says they are. But if you analyze it, you realize that the amount of money that the House wants to allocate over the next seven years is not enough to support the present level of benefits. It's as simple as that. Although it looks like a lot money, it won't do it.

Putting Medicaid back to the states in block grants is another idea. That won't work either, because we all know many of the states don't have the capacity to administrate a state program well. That has been proven in the Medicaid program and some of the other programs. They just don't have the ability to do it. And the closer you get to the local courthouse, the more strange things happen. As the Chinese say, "The more eyes that are watching, the less strange things happen." And we do have more eyes in Washington.

We also have had the congressional direction to be leaner, meaner, more greedy, less altruistic and with less social consciousness. That has been pushed by the Republican majority in the House and to some extent in the Senate. This, in my view, sort of trickles down to the whole business community. There are a lot of business people, bean counters, money grubbers, and people who really don't care about anything except lining their own pockets, who have taken this government attitude to demonstrate greed, not caring about their customers

or the people who work for them. It used to be--and we all know that this is nothing new--that you could expect to work for a company for the rest of your life if you did a good job. Nowadays they estimate that the average person will work for ten different companies during their career. It's as if there is a go ahead for "greed is good".

I was looking at a cartoon from the New Yorker. One man is looking at the other and says, "Yes, the fact that you have been an outstanding employee for twenty-five years is going to look great on your résumé." That is the attitude that has developed in the last three years.

There is another cartoon here from the International Herald Tribune that shows the chairman of the board and the president, just the two of them in the board room, and they have a chart that shows the number of employees going down and the profits going up. There is a big sign saying "DOWNSIZING". Then the chairman says to the president, "The downside, of course, is it's your turn to clean the men's room."

Opinion letters and editorials are starting to come out, in which people are beginning to realize that this whole idea of "re-engineering," "downsizing," "outsourcing," and all of the cute little words and gibberish that they put on these new-style gimmicks, are not productive and represent poor management. These fads will go away, because anybody that knows anything about good management knows that a manager's job is to constantly build their staff. They bring in better people, move people on that no longer measure up, and redesign their table of organization. So "restructure" is not a new word. It's just a word for firing loyal employees and cutting your company down to where it cannot grow but makes more profit in the short run.

I have always been of the opinion that in order for a company to grow, you have to have many more people than are needed to operate the existing company, particularly in management. You need the extra capacity to get today's work done plus the work done in management to expand and develop. It's like allocating money for research and development. These people that are into the restructuring craze are cutting out all of the research and development because that does not make the shareholders any money short-term. So research and development, public relations, advertising, marketing, and management training are going by the wayside.

Hughes: What about good medicine?

Gumbiner: Well, what about it?

Hughes: Where does it fit into this scheme?

Gumbiner: It doesn't fit at all in the scheme of folks who are interested in simply maximizing shareholders' return. This fellow that took over from me [as chairman of the board of directors of FHP], Jack Anderson, is strictly an investor. He was an insurance executive; that is the best he has ever done. As far as I could find out, he has no experience in managing anything, although at one time he worked for Aetna, theoretically being in charge of bringing Aetna into the HMO [health maintenance organization] business. As I recall, at that time they bought the two sickest HMOs in the country and did nothing but consistently lose money in the HMO business. They were a joke in the industry.

One of my mistakes in the TakeCare acquisition was not investigating Mr. Anderson thoroughly enough to find out what his background was. I tried it, but I didn't seem to get very far in my inquiring. Probably as a word to the wise, anybody expecting to take over a company should pay more attention to the due diligence, to the point of hiring a financial investigating firm to find out exactly what the person's history is, where they have been, and what they did. I will get into that whole thing later.

Hughes: Do you think that your failure to thoroughly investigate Anderson, and perhaps others in TakeCare, was because at that stage you were expecting to fold TakeCare into FHP and, therefore, it wouldn't be quite as critical who the TakeCare people were?

Gumbiner: That is part of it. We were acquiring TakeCare. I should have been somewhat suspicious when Anderson wanted two seats on our board. At the time, we had nine board members. I thought that two seats out of nine would be reasonably safe. But I didn't calculate on how insidious and ruthless one individual can get. They bide their time and wait until people resign, or their target loses focus and gets ill as I did, or they find a jealous or resentful board member. If you go back to some of Machiavelli's writings, he said, "When you take over a country, you kill the ruling family." I think that Anderson expected me to do that, because part of the deal was the golden parachute for his ten senior executives. If he had taken us over, he would have executed our people, as he actually did when he replaced me.

I failed to remove the TakeCare executives because I thought that we could merge these two companies, acquire their better managers, and together build a bigger and more successful company. I naively thought Anderson would join me in helping me

build a bigger and better company, and that's why I made him chairman of the Audit and Finance Committee.

FHP Presence in Washington and Sacramento[1]

Hughes: Let's not get into the details of that quite yet, because I still want to paint this broader picture in a bit more detail. You told me in our previous interviews that FHP had legislative offices in both Washington [D.C.] and in Sacramento [California state capital]. Did those offices play any significant role in this move towards health reform?

Gumbiner: I was always of the opinion that, if you are in the health care movement or business, which is very politicized, you must be represented in Washington and Sacramento, since the majority of health care in this country is being paid for by the federal or state government, when you take into account the huge Medicare expenditures, Medicaid, federal employees, state employees, et cetera. Health care is such a sensitive topic politically that we have had round after round of people trying to do something about health care expenditures and coverage for everybody. FDR [President Franklin D. Roosevelt] tried it, [President Harry S] Truman tried it, and if I recall correctly, [President Richard M.] Nixon tried it. It never got any place against the entrenched political-medical establishment.

I felt that any organization of any size that is dealing with the federal government, or state and local government, in providing health care really has to have representation in Washington, and in our case also in California, since it's such a big state. If nothing else, the legislative office simply keeps the organization aware of what is happening on the legislative front so that they don't suddenly wake up some day and find out that some cataclysmic piece of legislation has just been passed that is either a deterrent to their ability to supply health care or is even threatening to the life of the organization.

Obviously, the senators and congressmen cannot read all of the bills that are put on their desks, nor understand them. Thousands of bills come across their desks annually. Even their staff can't read them all, no matter how big their staff is. So

[1]For more on this topic, see Gumbiner oral history I.

they do depend upon the lobbyists that work for different companies to give them a specialized opinion.

So not only is the legislative office responsible for keeping the company aware of what is happening in a defensive manner, but also they can be a progressive component of helping the legislators understand what the basic problems are in various legislative proposals.

In answer to your question, our office played no role because the administration stonewalled any advice or representation from the industry and, incidentally, they failed.

Hughes: Do you remember when FHP opened lobbying offices?

Gumbiner: I can remember it very vividly. In 1977, FHP got caught in a star chamber when Senator [Samuel] Nunn, who was then a junior senator from Georgia, was very interested in making his mark. He set up a Senate hearing investigation with just himself and his aides regarding the California Medi-Cal problem (that's what they called it). At that time Governor [Ronald] Reagan had decided to put as much as possible of the California Medi-Cal--that's the health care for the poor--into managed care. FHP had cut the cloth on that and had provided and developed the first health plan for Medicaid back in about 1968 or 1969. According to the then-legislative analyst, [A.] Alan Post, we were providing care [that was] as good if not better than the fee-for-service sector, and for about 25 percent less.

The mistake Governor Reagan made is a mistake that also could be made by the federal government in pushing all of Medicare into managed care. At that time, in his eagerness to save the state money and to control the costs in the provision of care, he gave contracts to everybody who applied. Some of these folks, either intentionally or unintentionally, took contracts and enrolled people that they couldn't supply the care for. So the people just didn't get the care, and it became a debacle. The result of all of that was that we all got tarred by the same brush.

FHP was known as the state of California's premier program. The secretary of health at that time--I can't remember his name, but he was voted as the most incompetent secretary of health in California history--simply canceled all of the contracts for every health plan.

The trade association, Group Health Association of America [GHAA], when I asked them what was going on and what should I do about testifying, responded, "Oh, we know you're a good guy.

Just go in and tell the truth." Well, that turned out to be bad advice, because fundamentally, this investigation was a star chamber, à la Joe McCarthy: they were not interested in the truth, but were interested in publicity for Mr. Nunn and something dramatic. They were trying to prove that everybody involved was a crook. As a result of this, we lost our medical contract and about 50 percent of our income over a weekend.

Incidentally, we had the state of California coming around six months later asking us to take the contract back again. I was impressed that time by the fact that I couldn't depend on the trade association or anybody else to give me reasonable advice on what I should do, and [decided] that I would have to have my own legislative office.

Kaiser Permanente had a similar Medi-Cal/Medicaid program. They were not included in that investigation, because they had a Washington office. Their legislative office had called me and warned me about that a year or two ahead of time. Their lobbyist had been working diligently to get Kaiser Permanente exculpated, and he did. They were not even mentioned.

Hughes: So that was your impetus to establish a Washington office?

Gumbiner: Yes, a good lesson. It's like an insurance policy. You buy an insurance policy to insure your house from burning down, but probably in your lifetime your house never does burn down. But that doesn't mean you cancel your fire insurance. The people now in control of FHP have canceled that Washington office. They just don't understand that. They closed that office when we had probably the best legislative person in Washington working for us.

Hughes: This was right after the takeover?

Gumbiner: It didn't take them long--three or four weeks. They closed up the Washington and the Sacramento offices.

Hughes: Amazing strategy.

Gumbiner: So I don't know why they just don't cancel all of their insurance, because that was the same concept. But they are insurance people, so they have insurance-type brains. They don't understand that they can be hit with very difficult problems on the legislative front and they are absolutely helpless without coverage there.

Hughes: Don't they look around and see what other health plans are doing?

Gumbiner: Well, strangely, as far as I know, in Washington, D.C., the only HMOs that have legislative offices now are Kaiser Permanente--they have three or four people--HIP [Health Insurance Plan] of New York has a person, and I believe two or three others have contract lobbyists, which is not the same. Contract lobbyists will do what you tell them to do and that's about all they will do, because they are trying to serve several masters simultaneously.

Hughes: So they don't take any initiative?

Gumbiner: They are not your person. With your own lobbyist--and I usually don't call them lobbyists because that really has a different connotation; it's really a legislative office--they are watchful for all of your interests on the legislative front. They also do a constant educational program for the legislators and their staff. Your own legislative office is focused on your organization's interests and problems and have responsibility only for you.

The American Hospital Association [AHA] has about twenty lobbyists. The American Medical Association [AMA] has a number of lobbyists.

Hughes: Obviously this is part of the general cost-cutting moves in the health care industry, but is it also leading to something else that you were saying, namely, that a different breed of person has moved in? These people are interested in serving their investors, and they don't have a broad perspective that sees that health care involves people at all levels of society.

Gumbiner: You are right but it is part of a general naiveté. If you think about it, there are probably 200 to up to 300 HMOs in this country. And if you think about the fact that there are less than a half a dozen that have Washington offices, you come to the conclusion that these people are fairly naive business people.

Hughes: Has that always been true?

Gumbiner: It's always been true. They think that perhaps, in some way, the trade association is going to lobby for them, which of course doesn't always happen because the trade association also has several masters, and they may or may not be that effective. There is a general low level of management foresight in the conceptual or broader picture since the HMOs or the health care field are intimately involved in the federal and state

governments' attitudes on health care. This should be a major HMO function.

Single-Payor Health Care

Hughes: You talked about your idea of the expansion of Medicare as a model for health care reform. Yet another idea that has been proposed for health care reform is the single-payor model, the Canadian model, where people have a card that they present to their doctor who submits a bill to some central government organization.

Gumbiner: I think the single payor was a red herring that was dragged across the path by the people that oppose reform. Because any way you turn, the federal government is the single payor of Medicare whether the federal government reimburses the insurance companies or the individual. I think that a better explanation of that is, the government as a direct payor versus the government as an indirect payor. Social Security does collect money from you out of your paycheck, and they do disburse the money. Whether they disburse the money through insurance companies or through HMOs or directly to the provider is the question.

Under Medicare today, they do both. In other words, they disburse the money to the doctor or patient, but they disburse it through fiscal intermediaries, for instance Blue Cross. Some of the big insurance companies have contracts with Medicare but only process the claims. So fundamentally, the government is disbursing it directly through a fiscal intermediary. The government doesn't actually process its own claims. They are paying HMOs. Under the HMO Act, the government pays a flat sum of a capitated amount--so much per head per month--and then the HMOs provide the care. There they are paying the provider group or the HMO who then pays the provider. In either system the government is the single payor--and that's the way it is today.

The difference between that and the Canadian system is that the Canadian system is not just one system; each one of the provinces has a different way of paying for care. There, the federal government disburses the money to the provinces, and the provinces each have a little different system of benefits and claims. But they do then disburse it directly to the provider of care, whether it be a doctor, a hospital, or other. Fundamentally, in the United States the federal government is the single payor. If the federal government had 70 or 80

percent of the total population under Medicare, they could decide as the payor to do it any way they wanted to do it and set the benefit levels and level of payment.

The Business of Health Care

Hughes: I am thinking about your role in health care over a period of time: the fact that you started out as a physician and ended up being a manager with a business approach. I think I don't have to look too far to read into your remarks this afternoon some problem with the investor approach to health care. And yet, you somehow managed to combine those two perspectives. FHP as an organization had to run efficiently along business lines, and yet you also had a more humanistic approach and philosophy, providing the best care for the least cost to a wide number of people. How could you succeed in doing that where others didn't?

Gumbiner: I don't think these goals are mutually exclusive. You can still be altruistic and have social consciousness and run a business. It's a little bizarre to me that people think that just because you are socially conscious, you can't run a business, and that if you run an organization effectively and efficiently, you have no social conscious or altruism. The Catholic church certainly is a well-run business, and they are supposed to be altruistic, and are, in a sense. Some universities, for instance, are run efficiently and still have education and research as a goal. There are all kinds of examples. I don't think that organizational efficiency and effectiveness is limited to the for-profit sector.

Hughes: No, but what you were saying about recent trends is that it is sort of a unidimensional approach--that the business aspect has taken over the humanitarian.

Gumbiner: I didn't say the business aspect; I said the interest of the investor has been given more prominence than the interest of the consumer/customer and the interest of the staff, which I think is wrong. Anybody that knows anything about management knows it's wrong, because unless your staff is with you and appreciates what you are doing and is singing from the same hymn book, you are not going to get any efficiency out of them. There is no way that you can intimidate people to make them work hard and effectively, no way!

Secondly, health care is like any other service industry. We are providing a service. We are not manufacturing a product. If you are in the service industry, you have to provide satisfactory service. If you are in the auto industry and you provide a product, i.e. a car, and it's not acceptable to the public, then you don't sell any cars. So, it's pretty simplistic.

The only way I can see that this investor-first interest or greedy "me-first" philosophy can succeed is if it is on a very short-term basis. On that basis, management tries to build as much profit into the organization as they can and then they sell it to somebody and bail out. Hopefully, they can hoodwink the people that they are selling it to not to recognize what problems short-sighted management with no backup or growth potential will create. Sometimes the investors don't care; they just want to buy into the industry--the HMO field, or an HMO may want just to buy the number of enrollees. They really don't care whether the number of enrollees is being served very well, or if the price of the service is correct, or if what they are paying the staff or the providers is correct, all of which has an effect upon whether they are to fail or succeed.

Hughes: The bottom line is, if an organization doesn't provide good medical care and good service, that's going to be corrective in itself eventually.

Gumbiner: It may be corrective in the sense that the investors will eventually lose money but some will sell out, perhaps beforehand they hope.

I think that the investors in a public company should get a reasonable return. They don't all have to become multi-millionaires, but should get a reasonable return on their investment. After all, who is invested in the public area? Pension plans and mutual funds owned by the average worker who also receives the medical care.

The market has changed dramatically in the last five, ten years. Ten years ago, you used to have a lot of what they called retail or individual investors. Now most of these people buy mutual funds, where many, many people have invested their savings into pension plans and including people with their 401(K)s. These are just average people. I am sure if you asked them, "Would you rather make your job secure and have your company be successful? Or make a couple percentage points more on your fund return?", I think they would tell you they would rather have a secure job and work for a successful company where they liked to work.

Management has taken poll after poll on what people value the most on the job. What they universally value most on the job is a good place to work. They want to feel good about going to work; they feel like they're achieving something and that they are providing a valuable service. They are not usually interested only in money as long as they earn what they consider reasonable; making money is down about third or fourth on things they want out of their career.

Hughes: And FHP was successful in providing that atmosphere?

Gumbiner: Well, I think so. I don't know if my secretaries handed you that whole pile of letters I got after I left.[1]

Hughes: They did. I haven't had a chance to go through it yet.

Gumbiner: Well, when you get a chance to look at it, you will see what's what. We were pretty successful in offering career opportunities and a good place to work. I had several different types of training programs for staff. My idea was to provide an opportunity for everybody to grow within the organization and really feel more fulfilled with the type of work they were doing.

Hughes: And that, again, was one of the programs that was cut?

Gumbiner: Yes, that was decimated immediately--the training programs, the management programs, and the MBA [master of business administration] internships. For instance, when this guy Anderson took over, he immediately cut my galleries out. He said, "We are not in the art business!" What he doesn't understand because he's so naive is that he is in the business of selling health plans, and the art galleries are part of that business. The art galleries are a tremendous public relations tool, and we got more good P.R. and advertising mileage out of those art galleries than you can ever get per dollar any place else. He didn't understand that. He is not a manager.

Hughes: Did you argue that point with him?

Gumbiner: I never got a chance to debate anything. I was displaced in a surprise attack. You have to realize that I was ill. I came out of surgery and two weeks later they called a special meeting and got rid of the Office of the President, which I had created to protect Bill [W. W.] Price because he couldn't handle the job. He thought I was trying to diminish him, but he was wrong.

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[1]See Appendix A.

Some board members were calling for his ousting. I was too sick to attend the next board meeting. Then the meeting after that, they snuck up behind me. The board members didn't say, "Let's have a debate, a discussion about Mr. Anderson's theories on how to run this company and Dr. Gumbiner's theories." That didn't happen. It was all done behind the scenes. It was all signed, sealed, and delivered.

When I walked into the meeting that day after [Mark] Hacken had quit a half an hour before the meeting, I didn't have the votes. I though I had the votes four to four, but behind my back [Joe] Prevratil had negotiated an arrangement with Hacken that in return for a half a million dollars of a so-called "termination settlement", he would resign from the board a half-hour before the board meeting. It was all set up. If he had resigned two days before, I could have thought about it a little bit and aborted the takeover. The timing was not a coincidence.

So there was no debate on this. I am not quite sure if the board really knew at that time the extent that Anderson was going to destroy this company. I cannot believe that Price was stupid enough to want to vote himself out of a job. As for these other two FHP board members that turned on me, perhaps it was more jealousy, envy, and resentment that motivated them rather than a desire to totally decimate and destroy the company.

Hughes: Well, we can get into that in more detail a little bit later. Is there anything more you want to say on this broader front?

Gumbiner: When you asked me how health care has changed, it is very interesting. It hasn't dramatically changed yet. I just think there is a meaner, less benevolent, caring atmosphere that flows down from the present Congress into business. A lot of people in business, particularly in for-profit public companies, are controlled by financial types. They just don't understand management, don't understand anything humanistic, and are just waiting for the signal. The signal came from Washington, "Yes, you don't have to have any social consciousness. You don't have to care about your fellow man or your employees. You don't have to have any long-range vision. You just go for it, line your pockets at others' expense."

I was walking down the street the other day and I saw a T-shirt that said, "Greed is Good".

Hughes: That goes along with your Four Horsemen of the Apocalypse philosophy.

Gumbiner: The Four Horsemen--envy, jealousy, greed, and hate--will destroy any organization. But interestingly enough, no one ever talks about these emotions and they remain hidden. But those emotions do exist.

In any event, the present orientation towards greed is a national catastrophe, as far as I can see. The feeling is, it's okay to be greedy and it's okay to exploit your fellow man just to line your pockets. To me, there is something wrong with that, because it's all right to be ambitious and try to make a living and do better financially. But when you are so wealthy that you don't need any more money, and yet you decimate an organization or wreck a whole concept and people's careers just to make some more money, it's bizarre.

Hughes: Well, even if you needed money, I think it's not exactly laudable. Presumably, a health organization--and I know you set up FHP not strictly as a money-making organization--provides a service for society.

Gumbiner: You are right; we were not running a discretionary service like a hotel or a restaurant. You don't necessarily have to go out to dinner that day; you can cook yourself some bacon and eggs at home. You don't have to go to a hotel; you can go to a motel or stay home. But if your child has a 104-degree temperature or you have a severe chest pain, you <u>have</u> to see somebody about it. Therein lies the whole problem, because the individual really does not have any choice. If you wanted to go to a hotel, you could go to a low-cost motel or to a very expensive five-star hotel; you have a choice. When you go out to a restaurant, you can get probably just as many calories by going to a fast-food place as you can by going to a fine dining place. But you have your choice. In products, you have your choice of what type of television or automobile you want to buy.

You don't have that choice in health care delivery. You don't know what it costs. And even if you know what it costs, you don't know if that is an appropriate cost or service. It is difficult to evaluate the provider care that you get. So it's a totally different situation. Health care is not really subject to market forces. The market theory dictates that the individual, the purchaser, can make a selection depending upon the quality versus the cost, if they wish. That does not usually occur in health care.

Now, with the HMO prepayment concept, the market concept gets closer because before you get sick, you can decide which HMO and benefits you want to buy. But on the other hand, some of the other elements still are there. It's hard to

differentiate between HMOs since a lot of HMOs are turning out to be nothing but brokerage companies. They make an agreement or contract with the provider, doctor, or hospital on one hand, and on the other hand they make an agreement with the consumer. Usually it's the employer organization that pays for it, and subsequently the employee through payroll deduction or less payment. These HMOs are doing nothing new but just replicating and continuing the old fee-for-service system.

This system changes in the staff model HMO, where the organization hires the doctors, pays them a salary, and then charges a flat amount per month to the consumer. There are many examples of this system, such as the military. Most of our congressmen go to a staff model HMO. They either go to the Walter Reed Army Hospital or the Bethesda Navy Hospital and/or the medical schools.

Medical schools are another example of staff models. They hire the faculty who work for the medical school on a salary and have the professors take care of the patients. So there are several examples of staff model HMOs.

Until we get rid of the fee-for-service system, we are not going to get away from the problem of obtaining satisfactory health care for a reasonable cost.

That's what FHP has turned into now, simply a brokerage company. They are getting rid of their staff models and their hospitals and they are turning into a brokerage company that is simply arranging contracts in an attempt to put off the risk of the provider. But that doesn't work very well because you can't control the quality and availability of care through these contracts.

HMOs: For-Profit versus Nonprofit

Hughes: What about the trend within the HMO community towards for-profit rather than the original nonprofit organizations? How does that affect this trend that we are talking about?

Gumbiner: I think that is a key question. What has happened with our FHP HMO is that we worked as a not-for-profit for twenty years. Then it became obvious to me that two things were happening. First, since we are mostly a staff model and needed funds to expand, we couldn't get funding through conventional loans because there wasn't anybody to co-sign or stand behind an

unsecured loan. Secondly, we were losing a lot of our good management people to for-profit organizations who were offering stock options, stock grants, and other marketing incentives.

So it seemed to me that we had to move to a for-profit format in order to generate the capital that we needed and attract personnel with stock options. If I remember correctly, initially this was simply a stock offering to raise money to pay for our first hospital. It took me three or four years to get that hospital financed. I finally had to go through the California Health Facilities Act for a loan, and that wasn't easy. So I said that if I have to do that forever, I will have a long grey beard before I get much done around here. That was pretty significant to me. The first public stock offering we mounted was to raise enough money to retire that loan, so we now owned our own hospital. That was pretty simple. We just sold part of the company stock and retired the loan. Now we didn't have to pay any debt service on the hospital; we were relieved of that expense.

Fundamentally, what we were doing was selling our company piecemeal through stock offerings. When we first started, I owned half the shares and the other managers owned the other half of the shares--simple. But in order to raise money, we had to start selling shares. So even if management hadn't sold any of their personal shares, we would have had to create more stock for sale, causing dilution. We converted and sold company stock to build the buildings and buy equipment. We ended up with the company more than half owned by investors as we expanded the number of shares and sold them. So we sold our company bit by bit.

Interestingly enough, the man that took over the company, this guy Anderson, only owns about 2.5 percent of the common stock. I think if you put everything together, common and preferred, he probably owns about 5 percent. That isn't enough to directly take over a company. So it's interesting that people can get in control through the back door with a reasonably small amount of stock. If it's a frontal takeover, then they have to buy a majority of the interest, over 50 percent, so they can control over 50 percent of the board of directors.

Hughes: What is a back-door takeover?

Gumbiner: A back-door takeover is where an individual or a group gets control of the board without buying a controlling interest in the stock and electing their slate of controlling board members. This guy Anderson has done this at least once before, I

understand. I will get into his history later. In a back-door takeover, in some way they either buy off the board members using company money or favors or discredit the present concepts and leadership one way or the other, and simply get control of the company through the board of directors. You don't have to own the company to get control of the company. You just have to have the votes on the board. So, that's the other takeover scheme.

Hughes: Was Anderson gambling, or did he have some assurance of some kind in advance?

Gumbiner: I really don't know. He received a premium for his stock in TakeCare, part of which was in preferred stock for which he was getting a dividend. He also had common stock. His only gamble was that the company would not do well and his stock would go down in price. The other side of his game was to get control of FHP, liquidate it, sell the parts for more than the value of the whole, using the return on the sales to cover operating losses and to make it seem profitable pushing the stock price up, and thus package it for sale at the highest price. When it's packaged for sale, then his stock price goes up, and he would make more money when the stock was sold. So he had nothing to lose if he didn't get control. He would just sit there and could eventually sell his stock. So he had little downside risk, only upside [possibilities].

How he managed to influence two of our board members is still a mystery to me, but we will get into it. I can tell you step by step how I perceived it was done.

You can control a company with a very small amount of stock. What's happening in American business today is that many of the founders may have a concept that made a company great but they moved out of the way either through death, retirement, or burden. Then other people come in who have different concepts and whose objectives are not to develop the founder's or the company's concepts but to do it their way for ego or material reasons. For some new people, if they are creative and achievement-oriented and want the company to grow, that's fine. It may just grow in a different direction.

Take Disney, for example. The company is now far from the concept of Walt Disney, but nevertheless they have a concept of a company which is growing and expanding and doing well. That's one situation which no one can argue with. On the other hand, if they are just there to destroy the company, to line their pockets, that's immoral and you can argue with that.

Some takeover artists, like Ross Perot, engaged in green mail. The company fundamentally bought him out just to get him off their board of directors. In other words, he got into these companies and caused them so much trouble and was such a threat to them that they bought him out. They paid him more for his stock than it was worth, just to get rid of him.

I think that any company that is buying a company should think about the major shareholder or board member that they are getting with the deal. If they are going to get a disruptive person or a predator, they should kill the deal right there because they are going to be in trouble. I may have been a little grandiose myself in thinking I could control Anderson and thinking that the board members were all on my side. It's a mistake not to have an investigating firm do a formal report on the people you are adding to your board of directors through the acquisition.

When a company gets to be well known, well financed, very progressive, with a lot of real estate and cash, it makes it a target for a predator to try to get hold of. They sell off the real estate, they grab the money; they dismember the company and use that to push up the stock price and line their pockets.

We knew that we were a prime target for a frontal takeover and prepared for it, but I just didn't conceive how a back-door takeover could work, that the management would collapse, and that the board members would betray the concepts that had built the company. But, being a student of human nature, I should have figured that out.

Hughes: Let me ask you just one, perhaps offensive, question. That is, business is like anything else; there are periods of development. Could some of this debacle be due to the fact that your idea of the staff model was passé?

Gumbiner: Well, that's what they tried to imply, that I was stuck with the staff model, but that was far from true. I had already converted FHP to almost 60 to 70 percent IPA [individual practice association--contracts with local doctors and hospitals for health care]. I saw the writing on the wall. I was always somewhat ahead of the field. My theory was a combined staff and IPA. I talked about that in the first oral history.

To me, a pure IPA model is very, very risky. All you have to do is lose the doctors' contracts and you are through, or the hospitals fill up and decide to raise their rates and you can't survive. The staff model combined with the IPA is much more secure, because that gives the HMO the capacity to either buy

another hospital in an area if necessary, or to put staff models in amongst the IPAs, which we did in Arizona, where there were not enough doctors in certain areas of Phoenix. We had to keep developing staff models to support the IPAs which, to me, is the only way to make it work. I used a staff model merely to keep the company secure and going forward. That also set the tone for the quality of care. We can have better quality with our own facilities; we can pick and choose our doctors, and we control the availability. This sets the standard for the rest of the community and they have to keep up to compete.

When we went into Guam, we converted the whole island from a place where you couldn't find doctors on Wednesdays or the weekend or after five o'clock to a place where you could get care twelve hours a day.[1] Our centers were open twelve hours a day, seven days a week. When the rest of the doctors began losing their patients to us, they turned around and learned some different manners at the health care table. The combined model ensures quality of care and growth and vitality of the organization.

I even had a vision to acquire a prefab modular company and build an inventory of health-care centers so I would have them immediately available to be placed in needed locations. But all this stuff is visionary and designed for long-range success. You don't make as much money on the bottom line because you are engaged in research, training, recruiting, and preparing for future growth. If you are building for the next ten years and you buy a pre-manufactured modular manufacturing company to provide facilities for the next ten years, that costs money. But that assures that you are going to be available to provide the care, rather than scurrying around in an IPA and trying to make a contract with an orthopedist when there are only three orthopedists in the area and none of them want a contract. The solution is to bring two orthopedists into a staff model that is right in the middle of that IPA, and then they are not so busy any more.

I developed the combined staff and IPA [model]. It was predominantly IPA but controlled by the staff model. I also developed the FHP matrix management system, where the corporate entity controlled all of the different regions and there was a corporate overlay that made sure that the marketing and the recruiting were done the same way. It was like any good far-flung organization, similar to a hotel chain like the Hilton, where all are units run on standards.

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[1]For more on this topic, see Gumbiner oral history I.

Hughes: Doesn't a staff model add to the overall HMO costs?

Gumbiner: Yes, but it is an investment in the future and in security and stability, a type of insurance well worth the cost. In my view, we cannot have health care reform without reforming the delivery system, and that means getting rid of all forms of fee-for-service and controlling the quality, availability, and access. The staff model does this.

Hughes: How does the staff model control an IPA?

Gumbiner: It's very simple. If the IPA doctors don't cooperate or they are not available, we can put a staff model unit in there to serve the consumers and eliminate them or increase the capacity.

Hughes: And they know that?

Gumbiner: That's right.

Managed Care, and More Changes in the Health Care Industry

Hughes: We have talked in general about health-care reform and related issues. I would like you to summarize by drawing the connections between the story we are about to tell of the FHP takeover and some of the themes that we were discussing earlier.

Gumbiner: What themes in particular would you like to discuss?

Hughes: We were talking about the possible discrepancy between the delivery of health care and investors' return, the consolidation of health plans, what the government is attempting to do with Medicare/Medicaid reform, and managed care as a solution to health-care delivery.

Gumbiner: These are slightly unrelated topics. Taking the consolidation of health-care programs: the consolidation of hospital chains and medical groups has been attempted for years. There is one theory that large, consolidated organizations that are nationwide work better. Unfortunately, it doesn't work quite that way in health care, because there are idiosyncrasies in certain geographic areas, particularly in the number of physicians, the type and number of specialties available, the general concept of how medicine is practiced, the delivery strategy, and the sophistication of the consumer. These idiosyncrasies cause a number of problems.

I don't know if consolidation as a strategy will ever be successful. Obviously, it is easier to run a larger organization than it is to run a smaller organization because you have a lot more backup and you can survive a lot more ups and downs.

What was the first topic?

Hughes: The possible discrepancy between investors' return and the delivery of good medicine.

Gumbiner: Right. But this conflict between corporate success, quality, and investors' return is not really related just to health care. The fact that U.S. management has lagged behind European and Japanese management due to its concentration on short-term profits and lack of long-term vision has been a lament of people that are sophisticated in management theory. The two--quality and investment return--are antithetical, because in order to generate short-term profits, the company cannot put money into research and development, new long-range concepts, management training, and all the things that will build a long-term successful organization. So people who strictly have investors' return as their motive are not interested in long-term corporate guarantees.

As I mentioned before, the majority of investments are now being made by fund managers who either manage mutual funds or pension funds. Their personal income and their bonuses each year are based upon how they do for that particular account per year. So, obviously, if they have a stock that is doing well, they will sell it in order to realize a profit at the end of the year. If the stock is doing poorly, they will sell it in order to get it off their books. Along the same line, they are mainly interested in what quarter-to-quarter earnings are.

That really feeds into the other part of that problem. That is, as any organization gets bigger, its percentage of growth in earnings has to be less, because it is a perfectly logical situation. If you have a company--just to pick a figure--that was making $100 million and it grew 20 percent, then it would grow $20 million in gross revenue. On the other hand, if a company was doing $1 billion, then it would have to grow $200 million in order to grow 20 percent. So as companies get bigger, their ability to maintain the same percentage growth is decreased because we are talking about bigger numbers, plus the fact that they are penetrating a finite market more deeply.

Finally, you just plain run out of customers. In other words, if you have 1 million people in your market and you have

penetrated 20 percent, then you have 200,000 people available in that market. If you penetrated up to 50 percent, you would have 500,000 people in the market. There is going to be a certain number of people in that market that are not going to go into your HMO, either because they don't have insurance, they don't work, or they are on another program, and you just run out of market. Therefore, eventually, if you follow that line of development, the short-term investors would simply stop investing in this industry.

When you reach a certain level of market penetration the industry can't grow at the same rate, and the investors will go into the electronics industry, or something similarly innovative, where they can get that 100 percent or 50 percent growth, or whatever it is, pretty rapidly. That is a long explanation of a short question.

Your last question, managed care as a solution, relates directly to Medicare; most of the general population will be covered for health care by Medicare as the age section grows larger. The federal government, in regard to increasing Medicare costs, is faced with either raising the income, i.e. payroll withholding (unpopular), decreasing benefits (impossible), or eliminating the 30 percent waste and 20 percent fraud which can only be done through managed care. But that means less for the providers and more political resistance from them.

FHP Under Bill Price

Hughes: My next thought was to talk about some of the changes in FHP under Price that had significance for the takeover. You are sighing.

Gumbiner: I retired in 1990, and I thought that I could retire as CEO and stop putting in my twelve hours a day, avoid the stress, and just be chairman. I would run the board of directors' meeting every quarter, and I would simply audit the agenda and take life easy. I would be there as an information and consulting resource for the management. They would consult with me and continue along the course that we had set. Price had been my number-two man for ten years, and for ten years he had appeared to agree with me on what we were doing. I thought that he would continue in the direction of long-range development of management backup, matrix support, innovative expansion, and independence and quality with the integrated staff model and IPA.

Hughes: Isn't that a usual course of action when a CEO retires? I mean, a chairman is not normally expected to run the company.

Gumbiner: Exactly. Unfortunately, Mr. Anderson is running the company as chairman. Anyway, what I had in mind was a traditional chairman's role.

Hughes: The one that you chose, not Anderson's?

Gumbiner: Yes. A chairman can be anything. Some chairmen micro-manage the company; they have the board behind them. They have what you call an "amen" board--whatever they say, the board says "amen". The chairman, in a sense, is the CEO. He can call the board together at a special meeting any time and fire the CEO.

Hughes: Does that work if the chairman is an adept person?

Gumbiner: I don't see how it can work, and I will tell you why. The chairman can't get enough information to make educated decisions unless he or she puts in the time to talk to the people, visit the sites, read the reports, go to the meetings, and do all the things you have to do to get information. The CEO's job is essentially one of gathering enough information upon which to make decisions. If the chairman is not available a significant amount of time, he can't get the information. It is different in the case of Anderson; he is simply dismantling and liquidating the company. There are no problems of creating--just orders to sell and fire.

Price, unfortunately, seemed to take the advice of the last person he talked to. He had a COO [chief operations officer] that was aggressive and definitely pushed his ideas, and Price seemed to go that way. So the first thing that happened was that Price canceled the matrix management. I called him and asked him why he had canceled the matrix management. We had spent years developing that. The reason we had worked on it and developed it was because of the type of organization we had; it was spread out geographically, managed a lot of knowledge workers, and was a complicated service. It was part financial projection, part insurance company, part health care delivery, part a medical group, and part a lot of different things.

Price tried to lie to me and tell me we still had the matrix, when in fact we didn't have the matrix.

Hughes: How could he lie about that? Either the company did or didn't.

Gumbiner: Well, he would say, "We still have it in part." What he did was take out certain sections, or he kept the corporate functional

portions but didn't give them power to manage in the regions; just oversight.

Hughes: Under what principle?

Gumbiner: He had this notion that if you decentralize things, they would work better because the people in the decentralized areas knew more about the local conditions than the corporate executives did. That is exactly the opposite philosophy from matrix because, in my thinking, you would have to have ten or twelve really competent, multi-talented CEOs, one in each region, to do that. They would have to know a lot about marketing, about health care delivery, about finance and many of the other different fields.

The probability of getting these dozen top executives all running these divisions is very low, because the divisions really weren't that big. In addition, you would lose the advantage of scale and standardization plus specialized support.

So in the matrix system, you found your best person in marketing who was a specialist in that, your best person in finance who was your chief financial officer, your best person in health-care delivery, and so forth. These specialists then controlled their areas in the regions along with their regional manager. They were experts, and the regional manager would operate and make all these things happen. They were broad-gauged specialists in coordination and delivery.

Hughes: So what happened under Price's system was that the regional managers then had to have a variety of expertise?

Gumbiner: Correct. This was not an unusual direction for a person like Price, who didn't have the ability to run the organization. He felt that by redirecting the responsibility to the regional managers, he would avoid personal responsibility in the central organization. In other words, if Arizona's marketing was weak, then it wasn't his problem because he didn't have a corporate marketing division. It was the Arizona manager's responsibility that the region's marketing was weak. That made life easy for Price.

Now, we see a bit of that in the federal government trying to refer block grants to the state governors. In that situation, if there is a block grant for Medicaid, care for the poor, it is deferred to a state governor. He is supposed to take the block grant, distribute the money, and take care of the poor. If he or she doesn't, it is really not the federal government's problem; it is that particular governor's problem.

Of course, anybody who thinks about it knows that it doesn't work, because you would have to have fifty governors, all fully competent, doing all these great innovative things and taking care of the poor.

So the heart of any company is it has a direction, a mission, a focus, and a policy. That policy goes throughout the company. You wouldn't have each Hilton hotel manager running the hotel the way he wanted to run it, or each McDonald's hamburger manager running things his way, and so on.

Hughes: We are naming Price, but in actual fact, wasn't [Mark] Hacken also part of this?

Gumbiner: In the beginning, there was a man named Pat Vitacolonna, who was the COO, who was pushing Price to change things. Pat was a very energetic, innovative guy, but, in my view, his judgment wasn't very good. One time, I came in to find that he had convinced Price to raise the surcharge on our prescription drugs in the Medicare program from three dollars per prescription drug to seven dollars. You can't raise the prescription drug surcharge threefold. You could possibly raise it from three dollars to four dollars, or maybe five dollars, but certainly not to seven. That is the bean counter's mentality, to take the number of prescriptions, multiply them by seven dollars, and voila, you have cured your financial problem, because now for every one of those prescriptions you are getting seven dollars, not three.

Except for one problem: you are probably going to get half the prescriptions filled, because these people are going to quit the program, or they are not going to buy the prescriptions. It destroys the very concept of a program in which prescription drugs are available at a very low cost so that people get them and use them and get well. If they have to pay seven dollars, they might not fill their prescriptions. When they don't, they get sicker, the hospital bills are higher, or they quit the program altogether.

Pat Vitacolonna was also great at putting a limit on the pharmacy program because he was previously a pharmacist. That again doesn't work, because if the concept is that you have your prescription drugs available for a patient stop-loss of three dollars a prescription, people will pick up the prescription drugs and take them and won't end up in a more expensive hospital bed. What is the difference in achieving this objective if you have a $600 cap and reach the $600, and now they have to pay full bore, so they don't get their prescriptions and they end up in the hospital?

Vitacolonna's concept was that that [policy] would get rid of people who were big users. In other words, people would know that they only had $600 worth of prescription drugs, and they would go join another program and quit our program. That didn't make a whole lot of sense to me anyhow, because people never kept track of when they were going to reach their $600. So all of a sudden, bingo, they didn't have prescription drugs covered, so they didn't get them; they didn't take them, and they ended up in the hospital. They knew they could get the drugs in the hospital if they were an inpatient. "Well, Doctor, I may die of a heart attack because I can't buy the medication I need, but if you put me in the hospital, I will be all right. On the way out, I will get my prescriptions filled."

Price went through all these different gimmicks. He went for a packaged quality control program gimmick when actually quality control is the concern of any good management group, not just some gimmick where somebody comes in and trains your people and leaves. The only people that make any money out of these quality control schemes are the people that put them together and sell them to other people.

Hughes: What was Price's quality control scheme?

Gumbiner: It was a scheme that was conceived by an individual. He sold it as a package and came in and trained people in quality control. The concept was that each person had responsibility for quality. Nothing revolutionary.

Hughes: What had FHP been doing in terms of quality control?

Gumbiner: We had quality control programs going. The doctors, the nurses, and other sectors all had the concept--it was part of the overall strategy--but first one must define quality.

Hughes: What was the difference?

Gumbiner: The difference was that now Price didn't have to worry about it or be responsible because he had this head of quality control that had this packaged, pre-masticated, pre-digested concept. All the outside organization had to do was set up the program and train the employees, and now the people do all the good things they are supposed to do. Which, of course, doesn't work, because you constantly have to reinforce it. It involves recruiting the right people because there are people that, no matter how much training you give them, they don't do it. Besides, Price no longer had these responsibilities.

Hughes: These were people hired just to do quality control?

Gumbiner: Right.

Hughes: But before, it had been up to the people actually doing the work to maintain quality?

Gumbiner: It was up to the people; it was part of their job. Just like teaching a class. When you teach a class, say you have twelve students. Some get A's, some B's, some C's, some D's, and some F's. Why is that? They all heard the same lecture. Well, because some are smarter than others, some care more than others, some concentrate, some pay attention.

There is no gimmick that is going to do quality control. It is the whole series of systems with constant reinforcement, getting rid of the people that can't do it, hiring people that can. The heart of quality control is the right people. You can't make a silk purse out of a sow's ear.

Hughes: We are talking about changes that played into the eventual takeover, and decentralization seems to be a theme. Were there other things that were being done to change the philosophy behind FHP?

Gumbiner: For one, they began selling IPAs in the staff model catchment area, which was a mistake. I told them that was a mistake in the beginning and that they were cannibalizing their own organization. In the staff model catchment area, you have the staff model and a medical group and a hospital in a certain geographic area that they can supply care to. Usually it is about a twenty-minute drive to a medical center and probably, in my view, about an hour drive to a hospital.

They had the notion that if we didn't put together IPAs in these catchment areas, in what they call overlay on the staff model, that other HMOs would come in there and take those customers. I didn't believe that because, sure, other IPAs may have taken some of the consumers, but we were giving away 100 percent of the opportunity for our staff models. If the staff models were competing against the IPA HMOs, they might get 50 percent of the consumers and the HMOs would get 50 percent.

So obviously what happened was it was a lot easier for the salesmen to sell an IPA. "Oh, would you like to have a doctor in your backyard?" "Who is your doctor? We'll make a contract with that doctor." As an alternative, they would have to sell the concept of one-stop health care and everything in one place in the staff model, perhaps a new concept. They lost sight of the fact that the fee-for-service community was the enemy of the staff model and the competitor and they were not our friends.

That was a big mistake, and obviously that led to the fact that the staff model didn't grow that fast and well, which it should have.

The staff model is one concept, the IPA is another concept, and you don't sell both of them in the same place. My concept of having the staff models and their catchment area surrounded by the IPAs outside the catchment area was a workable theory. An alternative idea was a combined staff model and IPA, as we had in Arizona and New Mexico, where we put in the IPAs and we plugged in the staff models, which were just medical centers and doctors in the places where we didn't have IPA doctors.

Hughes: Where you didn't have IPAs?

Gumbiner: Yes, where the doctors didn't exist. In the south part of Phoenix there is a big housing development, and there are only five doctors there. Obviously, these people were as busy as they could be and weren't interested in cooperating with anybody, so there weren't any available doctors [for an IPA]. We put a ten-doctor staff model in there. One of the failings of the IPA is that you can only deal with the doctors that exist there. You really can't develop a health-care delivery system, because if you only have two orthopedic surgeons and you really need five orthopedic surgeons, then you can't get adequate orthopedic services.

What you do then in the combined program is you put three orthopedic surgeons into your staff model, so you can actually fill in for the service that you lack from the IPA.

Hughes: In general, the control over an IPA is minimal compared to a staff model?

Gumbiner: Absolutely. Number one, you can't require doctors in an IPA to work at a particular time. If it is the habit in the community for all the doctors to play golf on Wednesday afternoon and not to be in their office on Saturday and Sunday, too bad; you can't find a doctor. You have to go to the emergency room and find a doctor who may not speak English.

Hughes: So, in a sense, you have to take what you can get.

Gumbiner: Exactly. You take what you can get in quality, availability, and accessibility. Doctors are like anybody else. Some are lazy, some are diligent, and so forth.

Hughes: Do you think that is going to change with this new picture that is emerging in health care? The physicians, even in what might

be loosely phrased as an IPA, are going to have to kowtow to more guidelines about medical practice. And if so, how would that control be exerted?

Gumbiner: If you control their pocketbooks, their hearts and minds will follow.

Hughes: That's very "Gumbinerian"!

Gumbiner: Unfortunately, money is not the ultimate motivation, but it can be a preventer or persuader. We all know about sales organizations in which you may have ten salesmen of which two salesmen are selling 80 percent of the product or service. Yet, what happened to the other eight salesmen on the same commission basis, who are not making a very good living? They are either lazy, incompetent salesmen, they don't like sales, or one thing or another.

You have the same thing in doctors. At least in doctors there is a baseline--people that have gotten through medical school are mostly hard-working and smart enough to have done so. On the other hand, what happens to them ten years out is something else again. Some people may not want to work that hard any more. They have expectations, and they may have what I call the "entitlement theory". After they go through medical school, they are entitled to make a good living because they did all this hard work and have an M.D. degree.

I went to medical school with people whom the military sent to medical school, and they tried to tell me what they were entitled to because they went to medical school with all that hard work and expense. Most of them went to medical school so that they wouldn't get shot at in World War II. Many doctors have the entitlement attitude; I'm not saying all of them.

I think that when there are more restraints on what they can do, some physicians will make less because they won't work any harder; they won't change their particular habits, because they can't. They are not going to change their attitude or their view of life. If money were the great motivator, then we would have no poor people. Everybody would get retraining. They would work hard and deny immediate gratification for long term success. We would have no lower middle class. We would have nobody complaining about inadequate income, because everybody would work effectively for fifteen hours a day, seven days a week.

So I think that money is not the great motivator. In all the studies we have done on our doctors and our managers, money

is down there third or fourth as a objective to work for. Interestingly enough, money is lower on the scale of things doctors work for than it is with managers. For most people, in all the studies I've done and all I've seen, the main thing they want out of a job or career is a place in which they enjoy working, a feeling that they are contributing, and a sense of control over their own destiny. Money is down third or fourth, as long as it is adequate, except for the investors, the bean counters, who are in the game just for money. For some reason, to the materialistic mind, if they can own a bigger house, buy a bigger car, then that is a measure of their achievement.

In my view, accumulating money is not a measure of achievement. The materialistic person will never leave a mark on history or contribute to social welfare. That is the major difference, I think, with the people like Price and [Jack] Massimino who are managing FHP now. They have no achievement orientation whatsoever, other than making money for themselves. They also allow people on Wall Street to frighten them. People on Wall Street are so imbued with money-making, they lose sight of other more satisfying, more altruistic objectives. They will just work on anything that's easy to get. They lose their objectivity and any broad-range perspective. So, all they do is work in this money field day in and day out, and their goal is how much money they can make for themselves or their clients. They lose sight of the larger world.

Hughes: How has Wall Street gotten to Price and Massimino?

Gumbiner: These guys would go to the East Coast and make quarterly presentations to the financial analysts, fund managers, and investors. Whereas, if somebody on Wall Street said something to me after a presentation, I would say, "No, I don't agree with that. We are not going to do that." For example, if somebody said, "Why don't you generate more earnings per quarter?", I would say, "No, we are not generating more earnings per quarter because we are pumping our earnings into future development and long-term success by training people, developing new concepts, building for the future, and returning something to society. By investing in training consumers about nutrition and alternate lifestyles, such as stress management, we avoid problems and expensive medical care, but that does not immediately show up on the bottom line."

Hughes: Preventive medicine.

Gumbiner: Yes. The biggest part of preventive medicine is removing the barrier for the potential patient in receiving health care. The barrier is that they think it is going to cost them fifty,

sixty, or a hundred dollars to visit the doctor. In the low-income areas, they say, "If I go to the doctor, it is going to cost me fifty dollars. I want to be fifty-dollars sick." So they end up in the hospital. But Wall Street could not conceive of investment to pay for long-term overall gain because it doesn't increase the price per share the next quarter. It actually deprives the company of money the next quarter in return for gain.

For instance, if we were to develop a medical school within an HMO, using the HMO hospitals which are already there, we would not only cut the cloth for a better, more efficient type of medical school, curriculum-wise, but also economy-wise we would be able to attract a better mix of altruistic people by lowering the tuition or even paying people to go to medical school, which is not so bizarre. During World War II, the U.S. government paid for all of us to go to medical school. We would avoid what we are going to have in the future, which is all upper-class white doctors. There are not many black or Latino doctors who can afford to go to medical school. We will end up with all upper-class white doctors.

But a medical school doesn't make any immediate money for the investors. You can imagine the public relations that such an ingredient would engender. You would raise your HMO to another level. You would be a medical school HMO, which would get rid of all this garbage about second-rate HMO doctors that they yap about, which is not true.

As I mentioned, when Anderson took over our company, the first thing he got rid of was the art galleries. He didn't understand. He said, "We are not in the art business." What he didn't understand was that we are in the business of marketing and enrolling people in the HMO, and the art galleries gave us lots of P.R. mileage, just like the medical school would have given us lots of mileage. But Wall Street doesn't think that way. So they intimidate these two guys and say, "Why aren't you making more money this quarter? Why do you have these training programs? That doesn't make money." Everybody knows that training programs do make money down the road, but they don't make money the next quarter.

More on Nonprofit versus For-Profit Health Care

Hughes: How does the health-care system avoid control by Wall Street? It used to be that health care was dominated by nonprofit organizations, nonprofit health plans.

Gumbiner: Not exactly, because all the big medical groups are for-profit. The doctors are for-profit. Let's face it. I know very few doctors that are nonprofit, that will work for nothing. A few maybe work for Doctors Without Borders or something like that. But in general, there is a difference in working to make a living and working just to pile more dollars on top of dollars.

Hughes: I was thinking in the organizational sense. If you have a nonprofit organization, you are less likely to give credibility to anything that an investment manager is going to tell you. You have no reason to.

Gumbiner: I don't think that is the answer, because not-for-profits will never get big enough to move fast enough to do what they have to do, development-wise or competitively, because they don't have the financing.

Hughes: Kaiser is a nonprofit.

Gumbiner: Kaiser is not doing well right now.

Hughes: Because of changes in the health care market?

Gumbiner: Yes. They decided they were being beat up by the IPAs. I talked to some of the Kaiser people who came down to talk to me about whether they should go the way that FHP went. I said, "No, you should not. You should just advertise and market better." That is the key. Nothing is ever bought; it's sold!

Hughes: You mean they were considering going to a for-profit model?

Gumbiner: No. They were considering getting rid of their hospitals. The Kaiser people are really not a great marketing operation. They were there first with a lot of money. Let's face it. When they started out, they didn't have any money. But guess what? Guess who signed all the notes? Henry J. Kaiser, who was not not-for-profit. That is the way that Kaiser got their hospitals and their medical groups. Henry J. Kaiser co-signed their notes. Easy, right? Well, most not-for-profits don't have that advantage.

Hughes: But that is true of only the very beginning history of Kaiser Permanente. Surely, Henry J. can't be pointed to as the reason for Kaiser's later success.

Gumbiner: By the time Henry J. Kaiser was out of the picture, they had such a big mass of gross and net income that the mass was carrying them. Now they are having trouble growing against the competition. Market share is the problem; not a problem of survival.

Hughes: And you attribute Kaiser's growth problems to poor salesmanship and marketing?

Gumbiner: No. It's their not-for-profit attitude. They are not that vigorous in their marketing. Let's face it: they don't attract the real dynamic managers at the top. That was one reason that I went for-profit: I was losing my managers. Why would somebody break their back working for a not-for-profit when they could move over and make several million dollars by doing the same amount of work in a for-profit?

Let me expand on this; it's contiguous. On one end, you have the not-for-profit HMOs which never have enough capital and can't attract really strong managers and move ahead dynamically. You usually attract people who like routine and want to avoid risk and don't want to be bothered with growing. Why would they? What is in it for them?

Then, you move on to the private for-profit HMOs--not public. Managers can achieve financial rewards there and don't have to worry about Wall Street. Wall Street and their misbegotten advice can be ignored, because in a private company the investors are usually also the management.

Then, you move over to the public-offered for-profits which are more or less beholden to Wall Street, depending upon how much of the company was sold to investors. If only 25 percent was sold, they could thumb their noses at the investors. If they sold a lot of their company to the public but the management and the board was strong and philosophically together, they could say, "Fine, so what if our stock is languishing at twenty dollars a share and a competitor's is up to forty dollars a share? We are not playing in that ball game. Let others chase their tail and try to get to sixty dollars a share and suffer the risks, problems, and uncertainty of manipulating the stock price. We are here to deliver health care and for long-term growth and stability."

Hughes: And that would be a viable stance?

Gumbiner: That would be a viable stance. There is nothing Wall Street can do about it, and there are some who can understand this.

Hughes: How do you keep your investors?

Gumbiner: That doesn't bother me. There is always somebody who is going to invest in your long-term program. There is always somebody who is going to buy a twenty-dollar share when all the other shares are forty dollars, because it is less expensive and has more opportunity to go up, not down.

The problem is that it is harder to raise money. If you want to sell another quarter of a million shares of stock in a public offering and you can get sixty dollars a share, the company will get $60 million for a million shares. If, on the other hand, your stock is twenty dollars a share, you are going to get $20 million for a million shares, right? You are selling the same portion of your company but for a lot less. That would be the impinging problem. You have to sell a larger portion of your company to raise money. But on the other hand, long-range, I think you would come out better.

It is just like the savings and loan industry. The savings and loans that were not running around in the 1980s making all these high-risk loans to developers didn't make a lot of money during those days. The savings and loans that were making all these strange loans to real estate developers for high rates made a lot of money short-range, but they went bankrupt eventually and were taken over. The question is, do you want to invest in an HMO that has a long-range strategy for success or one that has a short-range, high-risk strategy? Everybody knows this. There have been millions of things written about it. Wall Street is interested in short-range profits. They look at the stock market every day. Is the stock going up or down?

The Importance of Management with Vision

Hughes: So what you are saying is that the way that you ensure the delivery of top medicine and also avoid undue control by Wall Street is to have top managers and a knowledgeable board of directors?

Gumbiner: You have to have managers and a board of directors that are together, who know what the company wants to do and where it plans to be in the future. They must have a vision, have a theory, and the courage to stick to it. They cannot be

distracted by the sniping of the thirty-two-year-old guys on Wall Street that are only interested in short-range profits, who never ran anything in their lives, and who are trying to give your managers and board of directors advice in their own self-interest.

Now, I never listened to them. As a matter of fact, I would lead them, not let them lead me. I would tell them what we were going to do, why we were going to do it, and what I expected to happen. You know, it's a sales deal. I've watched Price and Massimino perform and all they do is side-step and make excuses. You don't do that. You tell people what your vision is and you lead them through it and convince them of its validity.

For instance, back in the late 1980s, all the Wall Street gurus said that Medicare risk contracts were not the way to go for HMOs; you shouldn't have a Medicare risk program with the federal government.[1] I said you should have a Medicare program. I stood there and told them, "Look, federal Medicare risk contracts are the way to go." In the future there will be more older people. We started in 1966 with 13 million risk-contract older people covered under Social Security, and now we have 37 million in 1996. We are going to have 60 million older people in 2010. I didn't care that they kept telling me, "Everybody says that Medicare risk contracts are bad. All you do is lose money. All the other HMOs have lost money." Forget it. We made money on it; we did a good job for the beneficiaries.

Now, ten years later, it's all turned around. All of the HMOs and doctors want Medicare risk contracts. So make up your mind objectively; don't listen to Wall Street.

Hughes: But you had had years and years of experience in health care delivery, and the experience was with different models and different forms. Most people don't have that. The problem with your argument is that it is difficult to find people that combine vision plus actual experience in the health care field.

Gumbiner: It's hard to find people with vision. Price had ten years with me. For ten years he followed me around the political halls of Washington and New York's financial world. Why didn't he understand what was going on? Why in the end did he take the advice of people with less success and less experience? Because he had no courage or self-confidence.

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[1]For more on this topic, see Gumbiner oral history I.

Hughes: But he had the experience, you think?

Gumbiner: Yes. He was there for ten years, all through the 1980s.

Hughes: So you don't think it is impossible to find people that combine those two attributes?

Gumbiner: They are there. There are just not too many of them around. It is hard to find people with successful experience, vision, and courage of their convictions.

Hughes: According to you, what happened in the FHP takeover is that people who had those attributes were replaced by investors.

Gumbiner: Visionaries have a hard time hanging on unless they are very practical and they become Machiavellian. Sometimes you lose your base because you get so carried away with the vision that you forget to include the troops. It is like the lieutenant that jumps up and charges forward. He looks around and he doesn't have anybody with him. The guys are all hiding in the foxholes; they are not with him.

Hughes: Did you have that problem?

Gumbiner: Oh yes, always. I had to drag them out of the foxholes to come along.

Hughes: Were they in the foxholes because your eyes were off on the horizon?

Gumbiner: Yes. I would say categorically, I did not pay enough attention to massaging and orienting the board of directors. I don't think they had a clue of what I was doing or what I was thinking about.

Hughes: All the way through, you mean?

Gumbiner: The last few years. I would say probably the last three or four years. I was so busy with Price and Massimino; I think Massimino was the most difficult problem of all, because he was a very crafty and self-centered young man. He was the one that kept pushing Price to dismember the company, decentralize it, and change it. These people that don't have vision and don't have courage always take the easy way out. What is the easy way out? Give the responsibility to somebody else. Decentralize, reinvent--give the responsibility to someone else.

Hughes: What should you have been doing?

Gumbiner: What I should have been doing is formally, through special board meetings, and informally, through socializing, apprising the board members of the problems as I saw them and bringing them along through the same process I had gone through to reach the same conclusion, particularly in regard to management. The managers should have been continuing the matrix, or some form of it, and marketing, marketing, marketing. They should have been marketing the staff model. As consultant and chairman, I attempted several times to get the organization to go into manufacturing pre-manufactured modular medical centers so FHP could expand faster. But when I turned my back, they would be building a one-of-a-kind "stick model". Now, you have to realize that if you as chairman don't go to the office every day to maintain contact, and the only contact you have is once every couple of weeks or so, management may do things behind your back.

Anderson's management style is to terrorize management. He simply liquidates people and departments. That doesn't take much effort. He calls Price up two or three times a week and tells him to fire this or that person or, since he has the majority of the board of directors behind him, Price will be liquidated if he objects.

I don't know if you have ever seen the picture "Caligula". Caligula makes a great statement. He says, "I don't care if they love me, as long as they fear me." Caligula periodically took three or four senators and had them killed. People would say, "Those are good men." So what. He simply replied, "They were disloyal. I don't want them to love me; I want them to fear me." In the end, he was murdered by the captain of his guard.

So that is Anderson's theory: it works to terrorize. But the people who are left are only the frightened and incompetent.

Communicating with FHP's Board of Directors

Hughes: The other point you just made is that the chairman needs to keep his board up to date on his philosophy. You mean to say that you weren't doing that?

Gumbiner: No, I wasn't doing that.

Hughes: Why was that?

Gumbiner: Because I was really burned out or bored. For thirty years, I had been conducting four board of directors meetings a year for FHP, four for the foundation, and committee meetings, and auditing, and reading minutes and reports. I resented going to another board meeting. It takes a couple of days just to go over the material to run a board meeting properly. You have to go over the financials and all the reports from management people and outsiders, as well as plan the agenda and review all board and committee reports. It's too much year after year.

Hughes: Were you doing that?

Gumbiner: Yes, I was doing that. I had to go over the agenda and make sure it was not too long, not too short, covered enough things. I had to make sure that the board members were on the right committees. I had to go to the committee meetings to see how they were doing. When you have about four or five committees and you have board meetings and they all meet quarterly, you are going to a number of meetings. Most of all, in chairing the meetings, it is necessary to concentrate on drawing certain people out and shutting others up, all without hurting their egos or creating implied or imagined slights.

Hughes: Were you doing any of that?

Gumbiner: I was doing that, and with preparation, reading all the material. The material the Audit and Finance Committee alone gave you was an inch and a half thick. I resented that. I had been doing it for years and years, and I didn't retire in 1990 to be that involved. I thought that I knew the board members well enough to relax and ignore the interpersonal relationships, but I think it takes constant, constant effort. You have to have them in for dinner parties, socialize, do one-on-ones, pretend to seek their advice. You have to do all these different things.

If you find a board member that you don't have confidence in and who you think is not contributing, you should get rid of him or her, either get them to retire and put them on an advisory committee, or when the time comes up for their reelection, you should very carefully review a list of criteria and if they don't measure up, you should not renominate them. Otherwise they will sense that they are not respected and ally themselves with any faction that is out to get you, (i.e. Anderson). Over the years, people change personality-wise, financially, politically--a good argument for term limitations.

One of my big problems is I was always looking for the eminently successful, qualified board member. In particular, I

was looking for board members who had worked as CEOs in the service industry and for big, successful companies. Those are hard to find. I didn't want people from the manufacturing industry because it is not the industry we are in. They don't understand what the service industry is. So I was searching for potential board members in the hotel industry, the restaurant industry, the airline industry, the amusement industry, all service industries. They were very hard to find. You would be amazed how many people I interviewed that were presidents of companies who were not acceptable. They didn't know management theory nor have a concept of organizational structure. They had no vision.

I talked to industry people after the takeover, and they said they couldn't figure out why Price was there so long. He was there so long because of my delinquency, because I didn't want to spend the effort to replace him and spend six months on a search. I was not focused.

Hughes: Also, you created the Office of the President, which presumably was at least partially designed to spread authority and remedy the situation. You essentially had two people instead of one.

Gumbiner: I created the Office of the President [October 1993] in order to help Price and to give more dimension and power to that office. He didn't understand that. Machiavelli says, "When you have an enemy, don't wound them, kill them." Price wasn't my enemy, but he became my enemy in his mind because he thought I was trying to diminish his authority. I had concluded that this job of running a big organization, in addition to expanding and growing, was too big a job for one person. Actually, I was trying to help him [by creating the Office of the President].

It was a serious mistake on my part to create the Office of the President. I should have grabbed the bull by the horns at that time and made a decision. What I was looking at was written evaluations of Price by all the board members, including my own evaluation, that didn't give Price a high enough evaluation to keep him. I was evaluating him at about 50 percent effectiveness. So I was faced with two possibilities: fire him or strengthen him.

Evaluating a CEO

Hughes: What sorts of things do you look at when you evaluate a CEO?

Gumbiner: I worked out a CEO evaluation form which contains things such as innovation, vision, communication, ability to prioritize, judgment, decisiveness, general management ability, achievement orientation, competence in various areas, political skills, broad-based knowledge on health care delivery, ability to focus on cost and quantity, presence and stature, honesty, humanistic character.

Hughes: All the board of directors used those criteria for evaluation?

Gumbiner: I was sitting on a hot potato, because it didn't appear to me that they thought that much of Price. Therefore, if based on the evaluations I had recommended that he be removed, I would have had to go on a search and I didn't feel that there was that much talent on the outside. There were also a lot of different things that were happening in my private life. I was worried about my prostate cancer, I was getting married again, and I didn't really want to take the time and energy to attempt to find and orient another CEO at that time, and that was a mistake. Perhaps I couldn't believe that Price would not improve.

I would say, as advice to anybody that is chairman of a board, if you don't have confidence in your CEO, get an evaluation from all your outside board members and sit down with them. Go over the problems, and if he or she does not measure up in the collective board members' appraisal, then you have to terminate that person. Then you have go out and look for somebody else and take your chances.

Hughes: So, in essence, your creation of the Office of the President was a stopgap measure?

Gumbiner: Correct. It was a temporary alternative. I thought that this fellow, Mark Hacken, who theoretically had put together the Thrifty Jr. chain, was strong enough and innovative enough to help Price focus and make decisions and make the Office of the President work. I thought that he agreed with my philosophy and would be an energetic surrogate for me. He told me that he was definitely in favor of centralization, not decentralization.

In reality, what happened was that Hacken wasn't strong enough, and this guy Massimino got together with Price and they rolled right over him. They lied to him. They would go to important meetings which they didn't tell him about, and they would keep information from him. They used every dirty trick they could think of to discredit him.

Hughes: Was Price from the start cognizant of the significance of what you were doing by creating this Office of the President?

Gumbiner: I thought he was, but in retrospect, he didn't want to understand it. I think his wife got on his case, too. She thought he was just wonderful. It was just one of those problems where you have a person that is just not up to the job. He would have made a good chief financial officer for a company someplace, or he might have made a reasonably good CEO for a small HMO, maybe in the nonprofit field. He had the ambition but not the ability. He was not decisive nor creative or courageous. They tried to unseat him about two years into his job.

Hughes: Who is "they"? The board?

Gumbiner: Pat Vitacolonna, the COO [chief operations officer], and certain members of the board tried to get rid of him. Their accusation was that he was indecisive, didn't know anything about the medical/HMO business. It wasn't the fact that he didn't know anything about the medical business; he just didn't know enough about management. But when somebody is your number-two person, it is easy for them to act like they know because they just say, "Yes, that's a good idea, fine." Then they carry things out.

Anyway, a lot of number-two people who get promoted to number one can't measure up to the ambiguities when they are sitting there alone and they have to make their own decisions. They don't have courage and they don't have decisiveness. They don't have focus, and then they can't do it. In Price's case, he leaned on his COO, who had his own agendas. So that was a mistake on my part.

I would say that unless the chairman pays attention to the board of directors and works with them constantly, the chairman will lose control, influence, and power. The chairman has to like and respect the board of directors. If there are people he doesn't like and doesn't respect, then he should get rid of those people, because they are not going to work well with him, and this comes out indirectly. Then these board members get resentful and look for ways to get rid of that chairman. They will line up with anybody.

There were certain Indian tribes that lined up with Cortez when he came in to Mexico because they hated the Aztecs. They were just looking for some way to get rid of the Aztecs. If it wasn't Cortez, it could have been any strong ally. I firmly believe that anybody could have done it. It didn't have to be Anderson. It is just too bad that it had to be a mercenary predator who wanted to wreck the company. If somebody like Anderson wanted to come in and build the company, these board

members, I believe, would have gone over to him just because they felt neglected and not consulted.

II THE MERGER OF FHP AND TAKECARE

The Concept of the TakeCare Acquisition

Hughes: Tell me how the acquisition of TakeCare came about? Whose idea was it?

Gumbiner: When I created the Office of the President [October 1993], that gave Price more time to do other things. He realized that he was about to be fired and he had to make some kind of a mark. So he hit upon the idea that he would make a major acquisition. That is not too hard. What you do is call up various investment bankers and tell them you are looking for a large acquisition. They make money by getting their percentage commission on the deal. If it is a multi-million-dollar company, they make a smaller percentage, but it is still a lot of money. They could care less whether the deal works or not. They just want to close it.

If they get a guy like Price who is desperate to close a deal, and the investment bankers want to close the deal, then the board has a very serious problem. Your board of directors may not get the right information, or an independent evaluation of the pros and cons of the proposed acquisition.

Hughes: Why would this be something that a person like Price, in a precarious position, would want to do?

Gumbiner: Perhaps you are like a lot of people who do not understand this part of business.

Hughes: I want you to state your answer here, because there will be people reading this book who don't come from a business background.

Gumbiner: The big deal these days is acquisition or merger. Some people think bigger is better; don't worry that less than one half of acquisitions work out. Price wanted to be a big deal. He wanted to make a major acquisition or merger so that he would look like a wonderful, progressive chief executive. So he got together with the investment bankers and they found TakeCare.

Now, Jack Anderson had been trying to peddle this company to a lot of different organizations. I found out later that he tried to peddle it to Blue Cross and some other folks, because he had dressed it up for sale. He was not charging enough for his programs and he was paying the doctors too much--two major problems. He had no management and the company was not growing; nothing was happening.

Hughes: What is behind that statement, "dressed up for sale"? How do you camouflage these things?

Gumbiner: Easy. You don't put any money into future development and acquisition--no research, no development, no backup management, no training. Instead, you drop that money to the bottom line. Then you turn around and increase the volume by a number of [consumer] bodies by undercutting the market and not charging enough for your product. So since you have very little management in place, you are spending less. You cut your costs, but you can't go on very long that way, because there is no future. You dress it up for sale by increasing the net profit through removing departments and functions you need to develop and grow, and increase sales by under pricing. Then you figure you are going to sell the company within a year so you will not suffer the consequence. You cut off all your research and development, your marketing, all your management training, all these costs that you would have for a long-term organization. You drop that money to the bottom line. It looks like you are making money, but you have a shell ready to crack.

I asked Anderson, "You don't have any backup for the chief executive. What would you do if you lost him?" He said, "We would have to scramble." I said, "That's not a good answer."

Negotiating the Deal

[Interview 2: February 13, 1996] ##

Gumbiner: In the fall of 1993, Hacken and Price flew down to see Anderson in Florida to convince him to sell TakeCare to FHP rather than

to United Health Care. Eventually they came up with a proposed deal, but the board and I didn't like the price, so we canned the deal and TakeCare went back on the block again.

Then Price and the underwriters revised the offer to a higher price. The investment bankers have a way of going back and manipulating the figures to show you that you can pay more for the company and in the end, in some way, it will work out. In retrospect, here is where we should have gotten an independent advisor to evaluate the soundness of the program.

In about December, 1993, I told Price and Hacken I was scheduled to go on a vacation over Christmas. I didn't conceive that anything would happen over Christmas on a deal that they had been working on for only a month. "No," they said, "nothing is going to happen for sixty days on this." I moved this vacation from New Year's week to Christmas week to make sure. "No, nothing is going to happen for sixty days," I was again reassured. So I left and went on a cruise on the west coast of Malaysia.

I no sooner got on the ship than I started getting faxes from these guys telling me that they were trying to close this deal with a letter of intent. I don't know whether Hacken was in on the deal or if he was just not very bright. I believe that Price, along with Hacken, tried to close behind my back so I couldn't question the validity of the assumptions.

The sum and substance of this is that they wanted to close the offer immediately. I told them, "You guys told me nothing was going to happen for sixty days. I'm not going to come running back to California on the chance that something is going to happen in the next two weeks." So the whole board flew out to Singapore with a legal advisor (on the company's dollar) to discuss this preliminary offer with me.

I really didn't have the data and was unable to focus on the deal, but I was confident that the rest of the board members and management had done their work. I felt that a preliminary offer was not a problem since, based on further investigations, we could actually drop the deal.

That was also a mistake. I don't think that good due diligence was done. I understand from some people just lately that the due diligence team had the information that TakeCare was undercharging the consumer and overpaying the doctors, but it never got past Price and Massimino. That information was stopped from ever getting to the board or to myself.

Hughes: Because they wanted the acquisition, regardless?

Gumbiner: Yes. We didn't get good information.

I think that another mistake was made right there by myself. That is, I should have hired a group of people to investigate Jack Anderson and his history in management and acquisitions. I remember at a board meeting when we were considering this deal, there was a question of Jack Anderson [TakeCare] getting two seats on the board. At least one or two the board members questioned that. I said, in my naiveté, "Well, we have a nine-member board. So what if they have two seats out of nine? We have seven."

Now, on the surface, this would appear to be a reasonable assumption. However, subsequently one of our board members [Richard Rodnick] resigned, so we didn't have seven; we had six. So all they had to do was get two of our members to swing over to their side and they had four. Now we didn't have nine board members; we had eight. They had four [supporters] and I had four.

It ended up finally as four and four. I had myself, Burke Gumbiner, Bill Price, and Mark Hacken on one side. They had Jack Anderson, his nominee Richard Burdge. Then they swung over Joe Prevratil and Warner Heineman, particularly Joe Prevratil, who was able to influence Heineman.

Hughes: Why was that?

Gumbiner: I have no idea. Heineman was fundamentally a chief loan officer at Union Bank, and he really wasn't much of a manager. Allegedly, he was in on the original coup to get rid of Price and me two years after I resigned as CEO. Prevratil alleged that he had turned him around and therefore broken the coup. Why I didn't pay more attention to that, I have no idea. But I was paying attention to the board of directors in that situation and not paying attention to management.

Just before we closed the TakeCare deal, I managed to get the board of directors to vote a by-laws change increasing the board size from nine to eleven members and began a search for two more qualified board members. Another mistake was made here, in that we should have elected two knowledgeable members at that meeting, probably doctors. That whole deal was a mess.

I would advise anybody, if they are going to put an unknown person on their board, they should have a dossier on that person: the date they were born, everything that they did financially, businesswise and so forth. It appeared later that Anderson had made similar deals where he had sold a company and then taken over another acquired company. I hadn't really figured that out yet, but if you find out something like that, then you don't let that person on your board.

Incidentally, I had inquired about Anderson in our Washington [legislative] office and amongst people in the industry, but without a formal inquiry, learned very little.

Hughes: You also were apparently critical of the attorneys who were advising you. I have a quote from a letter that you wrote in September, 1995: "The large amount of money we spent on attorneys advising us on how to defend a traditional take-over had nothing to do with what happened."[1] Meaning that it turned out to be a back-door takeover?

Gumbiner: That was [the gist of] the letter that I wrote to Mike Weinstock, who was our corporate attorney. He had spent eons of time and thousands of dollars setting up takeover defenses to keep predators from buying our stock and taking a dominant board position. The letter was not critical of the attorneys who were in on the TakeCare deal; it was just critical of our corporate attorney. He had not paid any attention to the possibility of a back-door deal. All he had to do was pick up the telephone and say, "Dr. Gumbiner, as chairman of the board, I think you should pay some attention to the problem that you may be subject to a back-door takeover and that Anderson is attempting to influence your board members."

Hughes: What do you have to say about the price that was paid? There were two offers made. The first time around, it was sixty-two dollars and fifty cents per share, and then within a matter of months the offer was raised to eighty dollars.

Gumbiner: I think sixty-two-fifty was probably too high, to tell you the truth, to pay for TakeCare. I think we should have let it go to somebody else. The problem was that Anderson was a good negotiator and was negotiating with Price, who was not a good negotiator. I was not in on it. Now, whether it was Price trying to keep me out of it, or my own natural desire not to get involved, or simply timing, since I thought that I had plenty of time to step in before it closed, I don't know. I

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[1]Robert Gumbiner to interviewer, September 20, 1995.

probably should have been negotiating with Anderson as one chairman to the other chairman, not leaving it up to the CEO.

I think the board was being manipulated by the CEO and the investment bankers because he needed brownie points and they, as I said, wanted to get the deal done to pick up their commission.

Hughes: What was the logic for substantially increasing the offer per share?

Gumbiner: The logic was that we were in a bidding war with United Health Care and they theoretically were offering more on an all-stock deal. It's like, "Going, going, gone." If you don't offer more, the other people will get the prize. Anderson got such a sweetheart deal, I couldn't believe it. He got preferred stock; he got common stock; he got a couple of board seats. We should have just told him, "This is all we are going to offer for this company, and if you don't like it, sell your company to somebody else."

At the time, I don't know what the confusion was, but I was personally pretty confused about what was going on, and I believed the investment bankers. I don't believe I fully understood the offers, nor did all of our board members. We had a couple of board members that wanted to do the acquisition. Price wanted to do the acquisition. They were willing to pay almost anything. Some investment bankers say we gave up a year's earnings to do this, which was a mistake.

In retrospect, we probably should have acquired a smaller, 20,000- to 50,000-person HMO, and let these big deals alone. I should have realized that Price and company were not up to managing that big of a company.

Hughes: There is another quote here from you, again to do with money. You said: "Health care reform, particularly pushing Medicare into managed care units, will put a lot more money"--and you stressed that--"on the table and thus[,] in the broader context, takeovers of this type will be a greater concern."[1]

Is there a lesson there as well? Because certainly there is a lot of money at stake here.

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[1]Ibid.

Gumbiner: It is simple mathematics. If you get $400 per person per month and you enroll 10,000 in Medicare, that's $4 million a month. That's a lot of money for not that many enrollees because of the high utilization cost, but the per sale cost is relatively low. Not only that, but you are being paid by the federal government, and that's like being paid with a government bond. Plus, you are being paid before you supply the service, i.e. the first of the month. When there are a lot of people trying to get that business and when there is a lot of money at the table, a lot of bad things happen.

Hughes: During the TakeCare merger, there were a lot of similar mergers going on in the health care industry.

Gumbiner: I wouldn't say a lot of similar mergers. There were other mergers and acquisitions going on but few that large. On the surface this one made perfect sense since the two organizations were complimentary; TakeCare was in northern California and Colorado and FHP was not. I think that probably we really needed the advice of a good acquisition person that had been in big acquisitions as to what we were doing there and what the potential problems were.

Hughes: Do you think the other mergers were better advised?

Gumbiner: I don't know. Let's face it, when you get advice from an investment banking group that is only going to make millions of dollars if the merger goes through, you are not getting objective advice. They are interested in putting that deal together, no matter what. If it is not a good idea to put somebody on your board from the acquired company who could be a problem, that doesn't mean anything to them. If you are going to pay eighty dollars a share when you should be paying sixty dollars a share, they could care less. As a matter of fact, they would rather close the deal for eighty dollars a share, because they are being paid on a percentage of the deal and they will make more.

I would advise making a flat-rate deal with your investment banker, not a percentage deal. Percentage deals are not in one's best interest. The more money on the table, the more they attempt to close the deal--<u>any</u> deal. I think what you need is a second opinion from people who are not in on the deal and will give you an objective opinion. I thought I had that from at least one of my board members [Richard Rodnick], who had been in the merger and acquisition field. But, in retrospect, I think he had probably been in smaller acquisitions and also may have been affected by the emotional factors, i.e. the chase and the prestige. I just think we

needed another dispassionate, objective opinion of whether this was a good deal or not for the company and how it would work out.

TakeCare Moves to Take Over

Hughes: The events which you view to have paved the way for TakeCare to take control of the board was the elimination of the Office of the President and termination and humiliation of Mark Hacken.[1]

Gumbiner: Yes. That was a power play by Anderson, just to see how far he could go in controlling my board members. If he could arrange that, then he knew he was lined up to maybe take over.

Hughes: So that was a psychological move?

Gumbiner: It was just a power play. The existence of the Office of the President didn't make any difference. Hacken's agreement was over in November [1995] and he was removed in June. He only had--July, August, September, October--about four months to go. So it didn't make any difference in the long run whether they eliminated him in June or they just didn't renew his contract in November. The only difference it made was a test of Anderson's strength, of whether or not he could turn two of my board members. Of course, he could get Price to vote for the elimination of Hacken, and once he did that, he knew that he had a good chance of taking over the company. Your comment on the termination of Hacken is an astute one because I believe that was part of the Anderson long-range plan to get rid of Hacken and thus decrease the FHP loyalists.

Corporate Culture Clash

Gumbiner: Several things happened before that were significant. When we acquired TakeCare, we knew that we had a totally dissimilar cultures, and we expected to assimilate them into the FHP culture. They were only interested in short-term gains. They were not interested in innovation, growth, developing management, and they weren't that interested in quality of care

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[1]Robert Gumbiner to FHP shareholders, December 1, 1995. Unless otherwise noted, references are to documents supplied to the interviewer by Gumbiner's office.

or marketing. They had grown by acquisition, not building, and knew nothing about health care, being IPA brokers (i.e. insurance people), not staff model providers.

In my view, we were unable to change their culture because they still had the same leadership. The only way to have done it would have been to fire their senior managers, (all of whom had golden parachutes), and replace them with FHP managers. In the words of Machiavelli's book, The Prince, "Kill the ruling family."

It is very difficult to merge two companies unless the culture of the company that has been acquired is changed to correspond with the acquirer. Obviously, the acquirer is more successful than the acquiree, or they wouldn't be able to acquire. In order to do that, they have to eliminate the leadership of the company that has been acquired by removing its management and replacing those people with the management of the company that is doing the acquiring. Otherwise, it will be impossible to merge the two companies since it will be impossible to discontinue the attitudes, customs, and cultures of the acquired company and replace it with those of the acquirer.

I failed to do this, and what is even worse, in some instances, I moved their management in over ours; for instance, in Denver, in California, and in our EDP [electronic data processing] Department. I was thinking that we could utilize any good managers they had and retrain them, but this was a big mistake.

Most important, when you bring some TakeCare board members onto your board, you are bringing their culture and their thinking onto your board. This can fatally wreck the direction and focus of your board because it creates defection, particularly if you are bringing on very focused and aggressive people from their board. They will attempt to change your board to their culture. Therefore, the chairman must continually communicate with the board of directors and evaluate the board members, removing the disloyal, the incompetent, the hostile. It is important to make sure that you have your friendly votes and do not have any undermining from your board members, particularly from the board members you acquire from the other company.

The best thing is to never acquire those board members. If you are paying a premium for the other company, then their board members should not be allowed on your board. Some might say that you are developing a board that doesn't contribute and

doesn't question your management or your chairman, but on the other hand, you wish to have constructive criticism, not destructive undermining and plotting by people who have an agenda to destroy your company's direction.

In balance, the chairman is better off to have friendly votes to get things done and preserve the culture. As the founder and chairman gets older and loses interest and has decreased energy, it is even more important to have a plan to retain power and a good succession program. Otherwise, the younger, more energetic management who are hungrier will line up the board members--there are always some envious or dissatisfied members, those who imagine slights or insults--and attempt to depose you, which is an age-old problem.

Be sure you can control the information. Information going to the board of directors should always go through the chairman to clear it for accuracy and make sure there is not some secret agenda. The chairman must remain in control if he wants to stay around. The chairman must plan for succession if he wants to go. Obviously, he must go some day. Therefore, it is important to have a succession plan so that the policies, the mission, the philosophy of that company continues.

Hughes: You said that before the acquisition TakeCare was actually three companies, three not very well integrated companies.

Gumbiner: Exactly. There were three acquired companies that were somewhat disorganized and disintegrating, not integrated. So I made another mistake there when I leaned too much on my management people for advice. You have to remember, I wasn't trying to run this company; I was trying to be the chairman. As I remember, I gave them some bad advice. I said about the TakeCare management, "Why don't we just try to use them? Because if they have any management talent, we can use it." Naively, I was thinking that they were on the same wavelength that I was, that they were going to try to work together with us and build a bigger and better company, when in fact that was not what they were up to. They were up to taking over our company. There is a total difference there.

[R. Judd] Jessup, the former CEO of TakeCare, then became a pipeline for Anderson getting all the information he needed about the company, whenever he needed it. Since Price was weak and timid, and Jessup didn't know much about the business but he was aggressive, it was easy for Anderson. I would advise anybody that when they acquire a company like that, they fire all their chief executives and put their own executives in their place. That is the only way to change their culture. We

couldn't change their culture because their executives were there. Remember, we didn't have a strong central corporate entity and we didn't have the matrix system anymore--Price had destroyed that.

Hughes: When you acquire a company, one of the things that you acquire is management expertise. So what you are doing, in a sense, is cutting your profits by paying top dollar for supposed expertise that you then dismiss.

Gumbiner: You could take that position only if you are as naive as I was. The clue was that when Anderson negotiated the deal, he negotiated golden parachutes for his ten top managers. If he were I, he would have fired them. You cannot change a culture if their management is still in place. Their culture had been there too long. Their culture was to get short-term gain by liquidation instead of by building. If you have somebody like that who is not interested in going together with you in building a bigger and better company, and they are interested in doing it their way, I just think you are better off firing their top management and putting your top management in there. Besides, we didn't acquire them for their management but for their enrollment, their market.

If we had had our matrix system, it would have been a piece of cake, because our marketing people would have imposed our marketing policies on them. Our financial people would have imposed our financial policy on them. Our operating people would have imposed our operating systems. But we didn't have that.

Hughes: Are you sure that that is good advice across the board? I would think that yours is a radical position.

Gumbiner: I'm sure of it. If their management is still in place, they are going to keep going towards their goals and policies, not yours.

Hughes: You don't believe that there are cases where one of the rationales for the merger or acquisition is because the company being acquired recognizes that the philosophy and vision of the company acquiring them is more suited for the particular business context?

Gumbiner: Well, that's in all the textbooks, but it is wrong! That is one of the textbook reasons for acquiring a company. If you don't have enough management and they have management, you acquire them for their management. But in this case they were

being acquired to sell their stake to the highest bidder, i.e. to make money.

You acquire management only if you want to give up your policies. We were a very strong, vibrant organization with good management depth. We knew which way we were going. We had a policy. TakeCare was weak in management with no depth. They had no orientation towards innovation and growth. I am just saying that if you want this idea of merging cultures of two companies to be successful, you get rid of all their senior management. Then you have a good chance of merging the cultures, because now you have put your senior managers in their managers' place, and now you can merge them and you can make the culture work. In any event, we didn't do that.

The Northern California Market

Gumbiner: The major reason I had agreed to this acquisition was because TakeCare had 300,000 commercial members in northern California, and I wanted to enroll 300,000 Medicare members there. The existing 50-50 rule meant that I needed the 300,000 commercial members in order to enroll the 300,000 Medicare members. That was the major reason I agreed to this. I wasn't that concerned about the enrollment they had in Denver or Ohio or Illinois.

Hughes: So you saw the northern California market as the plum?

Gumbiner: That's right. It was simple mathematics. If you enroll 100,000 new Medicare members in northern California at $400 per member per month, you raise your return to your shareholders by twenty or thirty cents per share annually, a significant amount.

But that never happened. Price, for some reason, never put the right management people in northern California. He put untrained FHP people up there, and TakeCare continued to run their northern California operation just the way they always had, without coordinating with FHP, and FHP never took advantage of the major reason for the acquisition.

Hughes: Also, wasn't there a delay in getting approval to expand into northern California?

Gumbiner: Yes, in some counties. But in some of the counties TakeCare had the right to enroll Medicare, but they just weren't doing it. If we had eliminated their management and put our

strongest managers in, we could have done it. I would have put the strongest manager we had up there, with marching orders: "I want 50,000 Medicare members within six months or a year. I don't care how you get them. You can get them through the TakeCare system; you can get them through the FHP system, and if you can't get things done in Washington, pour on the heat, get it moving in Washington. Whatever you have to do." But Price didn't do that. He wasn't focused or dynamic enough.

Hughes: Plus the fact that he didn't have the Washington legislative office at that point.

Gumbiner: No, we had it at that point. The Washington legislative office didn't go until Anderson took over. This could all have been done in the time between closing the TakeCare deal in June of 1994 and Anderson's takeover, which was in June of 1995.

In the spring of 1994, we already had a small FHP operation up in northern California where we were not doing too well. When we finalized the TakeCare deal, we had 300,000 TakeCare commercial enrollees in northern California, which we could have used to bring in another 100,000 Medicare members. However, as I understood it, not all the counties that TakeCare and FHP were in had permission to enroll Medicare members. They were trying to get authority to merge FHP and TakeCare from the California Corporate Commissioner. At the same time, they were attempting to get permission from HCFA [Health Care Finance Administration] to enroll TakeCare and FHP Medicare members in all the different counties in northern California where they had commercial enrollment.

However, as I understood it, there were certain counties in which TakeCare had permission to enroll Medicare, and all we had to do was take over the TakeCare operation, remove their managers, put our management in, and consolidate it. It didn't make any difference if they were officially consolidated to go ahead and enroll Medicare through TakeCare, and that never happened.

Hughes: Now, you have given me two different ratios. You spoke of a 50-50 commercial-to-Medicare ratio, and just now you spoke of a three-to-one.

Gumbiner: I never said three-to-one; it's always been 50-50.

Hughes: I understood you to say that there were 300,000 commercial contracts, which allowed you to enroll 100,000 Medicare members.

Gumbiner: No, I didn't say that. I said there were 300,000 commercial contracts. We could have enrolled 300,000 based on the 50-50 ratio; we didn't plan to enroll 300,000. We planned to enroll 100,000, which would have brought in the necessary gross revenue to justify the acquisition.

Hughes: So that wasn't a legal decision; that was a business decision.

Gumbiner: And the market wasn't up there for 300,000.

Hughes: Do you want to talk about your resignation?

Gumbiner: My resignation was the result of the Anderson TakeCare takeover. It was obvious that I wasn't going to be able to reverse things immediately without expending a lot of energy, and I was very ill with complications of my recent surgery--under treatment for infection. My doctors were telling me that if I continued to be stressed out and fight with these people, that I wouldn't get well. So I made the decision that the most important thing in my life at that time was my health. If I had stayed on that board, I could not resist showing up at meetings and arguing with them to try to get the destruction turned around. It was fruitless at that time for me to do this; besides, I believed they would soon see a shareholders' suit.

But many things happened prior to that behind the scene. I think that what went wrong would be good lessons for CEOs, chairmen, and boards in managed health care organization acquisitions. The major problem was allowing TakeCare management to stay in place, which I think was a mistake since this precluded merging the cultures.

The other thing was the lack of speed and focus in accomplishing the planned strategy in northern California. If I were focusing and concentrating on the merger activity, I would have been all over management to enroll Medicare in northern California and get rid of the units in Illinois and Ohio. I personally should have flown up to northern California with our CEO, interviewed [our managers], made a decision on whether or not they should stay, and given marching orders up there.

If I had done that, then I would have been the CEO again. I was not getting paid to be the CEO, nor did I want to spend the time and energy, so why should I do it? So I was still depending on Price, and hopefully Hacken, being a surrogate for myself, to take care of it. I assumed, wrongly, that

management understood why we had paid so much for TakeCare and what the objective was.

Well, Hacken didn't take care of it. Hacken was as bad as Price in being timid and indecisive. Behind the scenes, Massimino was encouraging Price to roll over Hacken, to keep information from him, frustrate him and get him to quit, because Massimino had his own objective in controlling Price.

Meanwhile, Joe Prevratil, a board member, was playing a role. He had a meeting with my son Burke where he tried to use him as a messenger to me to not oppose the takeover, and suggested to Hacken that he quit. Somehow I couldn't believe it and didn't act. So somewhere in there this other underhanded stuff between Prevratil and Anderson was in progress. I don't know what was going on there, but Prevratil was working for Anderson out here on the West Coast.

Interestingly enough, somewhere in 1994, probably in the fall, somebody had a birthday party for Anderson in Texas to which they invited Price, Heineman, and Prevratil from my board, but they didn't invite me and they didn't invite Burke. That should have been another clue that something wrong was going on, but I still didn't act.

I have no idea how Anderson did this, to tell you the truth. He had to have a lot of cooperation from this fellow Prevratil, to work on Heineman here. I can't conceive that Anderson could do it by telephone from Connecticut. So he was working two ends. He had his ex-CEO Jessup, who was in charge of California, feeding him information, and had Prevratil working the board.

Toward the end, Price and Massimino independently had decided to move Jessup down a notch because he was failing as a manager, and to take him out of being in charge of California and put him someplace else. As soon as Anderson got wind of that after the takeover, Jessup was moved right back up to being in charge of California again. He immediately fired most of the FHP senior managers in California. The last I heard he was trying to manage twenty-four different direct-report managers. He fired all of the managers in Riverside; he left a young manager out there to run something like twelve or fifteen IPA networks. The person doesn't do anything because he can't manage that many.

The name of the game is called "managed care." If you don't manage the IPAs, do the prior authorizations, and check on availability, you don't have a managed care organization

anymore. So I don't know how they can survive. Besides, everyone knows that a company is measured by its management quality and depth.

Lessons Learned from the Back-door Takeover

Gumbiner: For the record, I would like to warn other people who are in the position that I was, after being the founder and CEO of a company for a number of years. If they want to become the chairman in the traditional manner and to step aside and allow someone else to be the CEO, they should be aware of potential problems. In my situation, the lack of knowledge of these dangers ended up in a takeover and dismember of the company. I think serious mistakes were made in three different areas.

Need to Assess a Proposed Acquisition

Gumbiner: The first mistake was made in the acquisition area. The TakeCare acquisition was simply too big an acquisition for our organization to digest, particularly with the management that we had on board. No one, including myself, paid enough attention to due diligence in relation to the type of people we were joining and what their motivations were. This could easily have been evaluated and forecasted by looking at TakeCare's history. If we had obtained a good history of what they had done, particularly of Mr. Anderson, we would have figured out that he was more of a predator than he was a builder of companies.

The acquisition teams that we sent to TakeCare were naive or not knowledgeable enough, and somehow their findings were not conveyed to me or the board. I think it was filtered by the [FHP] management, who desperately wanted to make the acquisition, and the board never got good information. Perhaps the board depended upon management and management did not do the job. Definitely, a board committee should control the investigation process and due diligence.

Equally important would be a second and even third opinion from an investment banker who is not involved in receiving a commission. An independent consultant should also be involved as to whether the price you are paying in cash and in various types of stock, warranties, and so forth, is too high. I think

that the acquisition was not carefully investigated enough. We did not have adequate independent consultation or teams of our people visiting to evaluate how TakeCare was managing and what their objective and culture was.

The second mistake was the way in which we attempted to merge the two companies. The mistake there was made in leaving the TakeCare senior managers in place, which meant it was almost impossible for us to change their culture. There should have been a better plan on how to merge the companies. We should have known that we needed to remove their senior management and identify our people to put in their place. I believe that instead of our better management going to Texas, which was a sinkhole, they should have gone to northern California to replace the TakeCare management.

Lastly, I think the back-door takeover itself, in which the acquired company's chairman became the acquiring company's chairman and imposed his philosophies on that company, was identical to a frontal takeover, in which he would have bought enough stock to control the company and impose his own philosophies. That back-door takeover could have been avoided. We attempted to make sure it would not happen when we increased the number of board members from nine to eleven at the time of the acquisition. Unfortunately I did not fill the new positions at that time. In retrospect, we probably should have increased the seats to fifteen and filled them immediately. Stacking the board is a pretty familiar tactic, ever since FDR [Franklin D. Roosevelt] stacked the [U.S.] Supreme Court; he could not deal with them, so he enlarged it. It would have been very simple for us to fill those eleven seats; I should have filled them with people I could trust, and most importantly, who had a liberal and visionary philosophy.

[FHP] being a health care provider, we should have had more doctor representation from the staff model on our board of directors. That would have preserved our objectives as a health care provider, not as a vehicle of creating wealth for investors.

Hughes: You didn't have any doctor board members except for yourself?

Gumbiner: No, and that was a mistake. I believe that we probably should have enlarged the board to fifteen and stacked it with anybody that was loyal and had the same objectives as we had in building a health care delivery company for the benefit of providers and consumers. Then we could have taken our time to look for qualified outside board members and deleted those board members who were not with us, did not understand

business, or who had personal wealth creation as their main objective and not the long-term benefit of the company.

Hughes: Including the two TakeCare board members?

Gumbiner: For instance, part of Anderson's deal was that he and Burdge would be on the board and he would be renominated. Now, we could have let his three-year term run out, and his tactics would have made a reasonably good case not to renominate him. He could have sued us for damages, but we could have made a case that he was destructive and counter-productive as a board member. That could have dragged on for years, but he would have been out of there.

So it was a function of time, if we had wanted to wait. In another year, [the term of] some other board member would have been up and we could have eliminated him. This process would continue until we had a decent board of directors.

The Care and Feeding of a Board of Directors

Gumbiner: In my dealing with the board of directors, a mistake I made was that I did not reorganize the board. I did not like some of these people; I did not trust them; I did not feel that they were going the same direction that I was and did not know the business. If you do not have a board of directors that you can trust, respect, and feel confident with, I think you are making a mistake to keep them.

On the other hand, the care and feeding of the board of directors is a critical element. I had been chairman so long that I was not paying attention to the board of directors. I was concerned with my health and my personal affairs. Besides, I was bored and tired and I did not want to work that hard any more. I think that anyone that wants to stay chairman has to constantly schmooze the board members, even if he knows them well. That is all the more reason that he or she should like them and trust them. Because if the chairman does not like them and trust them, he is not going to want to spend any time with them. Therefore, one thing feeds upon the other, and the board members become resentful, envious, jealous, and angry, so any lightning rod that comes up will cause a problem.

Hughes: What were your criteria for choosing board members prior to the acquisition?

Gumbiner: My problem was that I was attempting to locate qualified potential independent outside directors for key committees. The qualified board members that I was trying to find were people who had had experience in business, hopefully experience of being a chief executive officer of a large company in the service industry. Warner Heineman did not fit that at all! The only thing that he ever did was become a senior vice president of the Union Bank, which did not qualify him to run any large company. He was put on the board at the request of another board member who later died.

On our board, we had one member [Gunther Klaus] who died, one resigned [Richard Rodnick] because of his problems on another board that took a lot of his time, and the third, Mark Hacken, resigned because he was finessed and bought out by the opposition. So things can happen to your board members.

I think you have to constantly look at your board members, and if you do not trust them or like them, and you do not think that they understand your business or understand the concept that the company is working toward, you should eliminate them as they come up for reelection, even if you have to put somebody in there that is not that prominent but who understands what is going on.

Need for Strong Management

Gumbiner: The second part of that was that I did not trust the [FHP] management. I thought they were devious; I thought they were incompetent, but I did not do anything about it. I suppose the chairman (particularly the founder), if he knows that those people are not trustworthy and not competent, should recommend to the board that they be replaced, appoint a search committee, and get on with it.

Hughes: Were you faulted for not doing that?

Gumbiner: I fault myself for not doing that. Instead, I tried to prop up Bill Price by creating the Office of the President when I should have terminated him. The board was ready to terminate him and go on a search. For some reason, I did not do that. I think it was because I did not think it was easy to find a successor who knew the industry. I would be in the situation

again of finding someone, putting him in, allowing time for him to succeed or fail, then perhaps having to repeat the process again if he did not measure up. Besides, I thought the job was too big for one person.

Good advice would be to simply set guidelines. In other words, I would give a person a year, and if he does not achieve certain things in a year, then he is out of here. That is about the only way you can do it. So I would suggest that if you do not trust your management; you do not think they are competent, then you should get rid of them. Get people in there that you can trust and who can do the job.

Part of this is my fault because I was burned out, tired of the whole thing. I was not paying attention to it and I did not like some of the board members and management people, and they can usually tell pretty quickly when somebody does not like them.

Hughes: Maybe the lesson there is that even the chairman should have a definite term and meet certain criteria.

Gumbiner: That is probably right. As part of the whole procedure, you should have other people on the board who could become chairman and who understand the goals of the organization.

Justifying an Acquisition

Hughes: Why don't you talk about criteria for an acquisition? In your case, you thought the justification was the 50-50 deal with the commercial versus the Medicare membership in northern California. The reason that you gave was that Mr. Price needed this acquisition for his own personal reputation. But there must have been other reasons for the takeover that perhaps can be generalized.

Gumbiner: I think that if you have a good company that is well financed and doing good things, the only reasons for an acquisition are: one, you want to extend into another territory or another market; two, you need their management; three, you need their financing; or four, you need the product or service. Companies would like to buy FHP because they would like to have the 300,000 Medicare members that FHP has.

It is also a way to grow more rapidly. Otherwise, if you were to enroll 100,000 people a year and you lose 30,000,

netting out at 70,000, it would take you a long time to get to another 600,000 to 700,000 people. Whereas with an acquisition you would immediately get to that point by buying the bodies.

Some of these companies, like United Health Care Corp., do not really grow that much by marketing; they grow by acquisition. They trade stock for stock, but that is a self-generating thing. I can remember when United was a dog, but now they have grown by acquisition. The bigger they get, then the higher their stock price. The more successful they are, the more they can acquire another company less expensively, because they have stock that is of worth in an exchange.

Hughes: What do you think of that method of company growth?

Gumbiner: I do not think much of it, because it creates a loose federation and does not build towards an integrated objective. I think some of it is just a result of popularity: everybody is doing it, so if you are not acquiring a company, then you must not be a very successful company. The theory is that the stronger companies swallow the weaker companies.

I think FHP should have acquired smaller companies. PacifiCare acquires smaller companies--20,000 to 50,000--and that's the way to do it. They seem to have a good acquisition specialist on board who gets out there, tracking down these smaller companies, not just waiting for some investment banker to come up with something.

III ROBERT GUMBINER'S RESIGNATION, AND AFTERMATH

The June 21, 1995 Memo[1]

Hughes: This morning we were talking about the events that led to your resignation. We talked about the seventeen-page memo which you wrote on June 21, 1995, and which presumably was sent to the members of the board. Who else received it?

Gumbiner: Maybe senior management. I don't recall exactly.

Hughes: What sort of reaction did you get?

Gumbiner: I did not get any. It is just like I dropped it in the well; like those two letters that I sent to the investors in December.[2] They did not cause a ripple either. I expected at least to get a letter or two back, because there are dozens of investors.

One of two things could have happened. My letters could have gotten lost in the Christmas mail, but the one on the 28th should have found its way into the first-of-the-year mailbox. I think probably most people just scratched their heads and said, "Well, that's interesting; we'll see what happens," and put it in their files. As for the board of directors, I believe that the deal was set before my letter, promises were made, and they did not want to be bothered by reason.

Hughes: What could shareholders have done?

Gumbiner: Someone might have called me or sent me a fax and said, "Tell me more," or "What do you think of this and that?" Or merely said,

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[1]Robert Gumbiner to FHP Board of Directors, "FHP; Historical Review and Vision for the Future," June 21, 1995.

[2]Robert Gumbiner to FHP Shareholders, "Concerns with current FHP objectives and longterm shareholder value," December 1, 1995; Robert Gumbiner to "Dear Shareholder," December 28, 1995.

"I disagree with you," or "You're all wet." But I got no reaction. It's almost as if it was never sent.

Hughes: Even worse from your standpoint was not getting a reaction from your own board members?

Gumbiner: I did not get one reaction from that seventeen-page letter. I got reactions from management staff saying, "I heard there was a letter out; I would like to read it." I think the die was cast by that time. I think Prevratil and Heineman were the only ones that Anderson needed and had already made up their minds to vote Anderson in and vote me out.

You have to realize that a good part of the reason was based on emotion. Heineman, for instance, always wanted to be head of the audit committee, but I never made him head. It was probably a mistake on my part, but I did not think much of him. I did not think he knew anything about management. I thought he gave the company bad advice, and I thought he was spineless. He made the motion to substitute Anderson for me, and when the meeting was over he said to me, like a child, "Well you thought I could never do anything." I said, "Well, you got that right."

So Heineman became head of the audit committee, for which he received $25,000 a year in addition to the $40,000 a year board fee. No one was ever paid anything like that before. I believe he also received a 25,000 share stock option.

Prevratil became head of the executive committee, for which he received $50,000 a year, in addition to the $40,000 a year board fee, with an option for 50,000 shares of stock.

So I think that Anderson had already made his deal and promises of paying these people off.

Hughes: You think that was Anderson's decision?

Gumbiner: Oh, yes. Anderson was the instigator and always works through other people. At the annual meeting on November 15, 1995, he did not sit on the dais with Bill Price. You would think a new chairman would be up on the stage telling everyone what his vision is for the company. No, he sat in the audience. He never made a sound. At the meeting where they got rid of Hacken, they had this fellow Burdge make the motion. When they got rid of me, Anderson had Heineman make the motion.

Hughes: Is that passing the buck?

Gumbiner: No, it is just the way he operates. He is not passing the buck. He is more like the monkey with the cat's paw, if you remember that story.

Hughes: No.

Gumbiner: The hot chestnuts are on the stove, and the monkey takes the cat's paw and takes the hot chestnuts off the hot stove with the cat's paw, not his own hand. That's just the sneaky way Anderson operates behind the scenes.

November 15, 1995 Annual Meeting

Gumbiner: Interestingly enough, the night before that meeting, Joe Prevratil came to my house to talk to me. I was pretty sick; I didn't think I could get through that meeting the next day because I had complications after my surgery and I was on antibiotics and really felt bad. He came over and said, "Bob, I want to tell you I'm your friend. I want to tell you they will get rid of you tomorrow. I suggest you resign tonight." Here is a guy that wants to absolve his guilt and get me to resign.

I said, "You know, Joe, I wish you would stop saying that, because you are not my friend. I want to tell you, when you were down and out, I gave you an office to work in. When they wanted to kick you off the board because you owed us $300,000 in health plan dues, I protected you. I gave you $2 million to get the Queen Mary[1] started, which you have been living on for the last two years. You are such an ingrate that you are going to come here and tell me that they, which is really you, are going to vote against me." I told him to leave my house. He left grumbling. I was just too sick and disgusted to deal with him and his type of mentality.

Hughes: Now, was that the first word that you had had about what might happen the next day?

Gumbiner: I think it was. See, the interesting thing was that I had not been able to make the Utah board of directors meeting, which was two or three weeks before that, and I was trying to get well. So I went to Palm Springs for four or five days, just to sit around and try to recover.

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[1]Queen Mary ship project on the Long Beach waterfront.

While I was gone, which was up to the day before the meeting, who knows what was going on? Prevratil, unknown to me, may have already made a deal with Hacken to resign from the board half an hour before the meeting, for $400,000 to $500,000 plus giving him some stock options, as settlement for alleged wrongful dismissal from the Office of the President.

Hughes: That wrongful dismissal suit was pending?

Gumbiner: No, it was not pending at all. It was just something that they cooked up that Hacken might file. He never filed. It was just an excuse to give Hacken some money to get him out and get rid of his vote.

The funny thing was that I talked to Hacken two or three days before. I called him up and said, "Mark, I really need your vote. I want you to show up for this meeting." At the last board meeting, he had gone to the meeting in Utah but he had not gone to the dinner with these other directors that he was so mad at before the meeting. He also said, "Glad you canceled the board of directors meeting, because I can't stand those people."

I do not know what went on at the Utah meeting, but I think Prevratil and Anderson made hay over there and really worked on the takeover. Why Prevratil was dealing with Hacken rather than me as chairman is interesting. My illness, I think, played into their hands. You might say, "Why did they do it then rather than wait since it allowed you time to mount a proxy fight?" I think it was because they figured I could not fight back very well at the time.

Hughes: What was your son Burke's role in all of this?

Gumbiner: Burke didn't know anything about it, as far as I can see.[1]

Hughes: Was he at the Utah meeting?

Gumbiner: Yes.

Joe Prevratil and the RMS Foundation/Queen Mary

Gumbiner: There was another thing that was playing into it. I had a falling-out with Prevratil regarding the Queen Mary. I had set

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[1]See the oral history with Burke Gumbiner in this volume.

up this project on lease from the City of Long Beach as a not-for-profit foundation, the RMS Foundation, and contributed $2 million to fund it. Prevratil was supposed to run the ship, because he had run it before for Wrather Corporation, and I was suppose to be the chairman and set policy. As a non-profit I could not realize any return on the investment, it was just something I wanted to do for the City of Long Beach and have fun with it.

Well, about six months into that I realized that Prevratil did not know how to run the ship efficiently, and he had no vision or innovative ability. Besides, he was contracting for services and not putting them on the books. I found out that he had contracted for $1 million in advertising and had not paid these people, nor had he listed that as an account payable. I also found out that he was telling me that the restaurants were making money when they were losing money, because he was not putting any of the ship's overhead into their costs. I realized that no one would sue Joe Prevratil for "cooking the books" because he had nothing, but they might sue me, so I resigned from the Queen Mary board of directors within six months of taking it over.

Actually, I loaned $2 million to the Queen Mary, the RMS Foundation, which I set up to operate the Queen Mary, because in the beginning I could not give them the money since they were not yet a qualified not-for-profit. I had to wait until they got qualified. When they became qualified in the fall of 1994, I converted half of the money, $1 million, into a contribution. I placed a condition on that gift that they would have to give me accurate financial statements and a plan for what Joe planned to do to turn that thing around, and how close he was to the plan, i.e. what he was going to do with my grant. Putting a condition on a grant is a common practice to make sure the purpose is being accomplished.

Well, Prevratil refused to do that. He never gave me the financial information. He never gave it to the city. He was a year late with his financials [reports] to the city. As a result, I never contributed the other $1 million, so I was having a little bit of a to-do with him about that. I never anticipated I would ever get the money back, as he was about $5.5 million in debt on the project, living hand to mouth. I just wanted to know where my funds were going.

Prevratil may have been trying to get even with me, probably for severing my relations with the Queen Mary. Publicly I said I had other things I had to do, but privately I let him know I was leaving because I could not tolerate the way

he was mismanaging the ship. I had expected to go in there and have a little fun building it up--put in water transportation, new decorating, new concepts for the restaurants, a cabaret in the art deco bar, unique shops, and an art center. He did not want to do any of that, or anything new, even though I commissioned two decorators and we decorated two or three suites to show what could be done. We redecorated his office, essentially on my money, which I never got back. So there was a certain amount of ill feelings between us, you might say.

Finally, after Prevratil helped engineer the back-door takeover, I met with him and said, "You know, Joe, I do not want to be on any board of directors with you. I do not want to have anything to do with you, and I would suggest that you get off the FHP Foundation board." By that time, which I did not know, he was chairman of the FHP Executive Committee, and instead of his leaving the board, he got the FHP Executive Committee to remove me from the foundation board. After founding and spearheading the foundation for ten years, I thought I was a fixture. The rest of the board was aghast--you saw the letter from the attorney for that board of directors.

FHP Restructuring Begins

Gumbiner: It is amazing. I went to the FHP Foundation board meeting [July 10, 1995], again I was not feeling well, and Warner Heineman was sitting there. I really did not feel that they could remove me. In other words, I think I should have served out my term, but I really was too sick to argue with them. Prevratil had dropped that bomb on them before I walked in, that FHP was replacing me with Warner Heineman. I decided to resign rather than argue. And the funniest thing happened: they all gave me a tribute, including Price. Price got up and made a speech about what a wonderful guy I was and how much I had done for the foundation. It was amazing.

Burke just told me the other day that they brought in two new board members, and Price did a board orientation for them in which he spent most of the time extolling my achievements. Was Price dealing with reality or not?

Hughes: Well, from his standpoint, doesn't it make good sense? Here's an institution that is building on a long history.

Gumbiner: Yes, but then they removed their chairman and substituted a whole different set of values. You would think they would say, "Well, we reversed it. Our chairman was okay for the time he was around, but he wasn't up to the times, so we have changed."

Hughes: But they didn't say that?

Gumbiner: No. They just said, "He was a great visionary..." But they do not say that they are not following that vision any more. It's really all very odd.

More on Care and Feeding of a Board of Directors

Hughes: What else should be said before we get to your resignation?

Gumbiner: I do not know what can be said about it, other than the fact that, if the chairman does not pay attention to the board and does not have good allies, he is in trouble. I thought I had an ally in Joe Prevratil, who eventually destroyed my policies and would not support me.

Previously, I had a fellow named Gunther Klaus who was on my board for years. He was a great supporter, and I could depend on him to defend my backside. While I was out leading the troops, I at least had somebody back home guarding the door; but unfortunately he passed away.

It turned out that Prevratil was part of the takeover, so I guess the lesson to be learned is that you should not take anyone for granted, assume that they understand you, or that they have character. You have to stay close to everybody. It is hard work if you are chairman. You have to work at it. You cannot just sit back. I do not know how people like Ted Turner do it. They must work with their board constantly and put in a lot of time and energy to make sure it is dominated by loyalists.

Hughes: I certainly take your point of why a chairman needs board members that reflect his philosophy, but isn't there also a danger in having a board of yes-men or yes-women? I would think that one of the reasons that a chairman has a board is to get advice from a variety of viewpoints.

Gumbiner: Well, that's right. But once you decide to go one way, then the board should be together on it. There should not be divisions and people trying to undermine policy. Frank and open

discussion and constructive criticism is good, but cloak-and-dagger secret politics and manipulative behavior is bad.

The other mistake with many boards is they do not have people that understand its business. We did not have people that really understood the medical or HMO business. That was a mistake. Maybe you should have more board people that understand your industry. I also think the board probably should have term limits, if not written down, at least understood. I think a couple of terms is enough and they should be out of there. Otherwise, cliques form for counterproductive purposes. It should be a policy to regularly refresh the board by putting new people in there with new and different ideas. Most importantly, make sure that you do not have board members that have different agendas that are not in the best interest of the organization.

I wrote an article that was printed in the Director's Monthly[1] about why I felt that the policy of board members of public companies owning stock was a bad idea. It seems to be the current, popular idea that board members should own stock or have stock options, and therefore the board members will be interested in the stock price appreciation and the welfare of the investor.

Well, that is just the wrong angle from my view. I think board members should not own stock, because that makes them short-sighted. It's strange, but let's say they have options on 10,000 shares of stock. This will cause them to make decisions more for short-term stock gains than they will toward long-term development of the company. So I think they should not own stock in any form. They should simply be paid a reasonable professional fee, and they should be interested in serving on the board. No director should be paid an amount per year equal to more than 10 percent of his annual income, otherwise, he/she becomes dependent on that directorship income and can be manipulated to vote by implied threats to remove them.

That is a little contrary to what the general thinking is right now, but it begs the basic question, and that is, who does the company serve? Is it the greedy shareholder, or is it the customers and the loyal staff who are the major stakeholders? Shareholders should get a reasonable return on their investment but not at the expense of destroying the organization or affecting the quality of service.

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[1]"A Contrarian View," December 1995, pp. 12-13.

Board Composition

Gumbiner: There is a lot of general thought about organizing boards and who should be on a board. There are boards that have a large number of people, and they try to include a certain number of women, a certain number of ethnic minorities, and so forth. I often wonder, how can these boards possibly work? These people are not selected for their ability to contribute to the company's policy; they are selected because they represent certain segments of the population. I would imagine in those boards, most policy is predetermined behind the scenes.

Then there is also a controversy that goes back and forth about whether the chairman of the board and the CEO should be one and the same person. On most European boards, the chairman is different than the CEO. On American boards, they tend to be the same person. If they are the same person, logically it is hard to get rid of an incompetent CEO if he is also the chairman. On the other hand, if you have one person who is the chairman and another person who is the CEO, you can have policy conflict between the two.

Now, if you have a good, strong chairman, which I now advocate, he controls the board and gets rid of the CEO if there is a problem or lack of competence. Because if he or she does not control the board, then there will be destructive friction and, if the CEO is incompetent, the chairman cannot get rid of him. On the other hand, all the CEO has to do is butter up a few members of the board and his job is secure, whether he is competent or not, if the chairman is not strong and decisive. So that is another problem.

Board Size

Gumbiner: Then there is the problem of the large board versus the small board. I used to be an advocate of the small board, seven to nine members. I am not an advocate of that any more, because it can too easily be taken over and manipulated by a few determined individuals for their self-interests. Now I think a board of fifteen is probably a little more appropriate. It is harder to create self-interest objectives with fifteen members. In this situation that we just went though, all Anderson had to do was to get two votes; he had two already, so he had to get two of mine. That was made easy by the small eight-member board.

Hughes: Why did you formerly advocate a smaller board?

Gumbiner: I favored the small board before because it is easier to deal with and you can get things done. Just the exercise of trying to set a special board meeting for fifteen busy people can get difficult. It would be a lot easier to set a board meeting for seven or nine people. To call up seven or nine people and explain your position is a lot easier than trying to call up fifteen.

Hughes: It's also easier for a chairman to control a small board.

Gumbiner: Yes, you would think so. On the other hand, it is easier for another determined person to stampede a small board. It would be more difficult for a takeover to occur with a bigger board because of more differences of opinion. So there are pros and cons on both sides of this question.

You see giant boards for some companies of, say, twenty-six people. You often see them on not-for-profit organizations. It is very unwieldy. You have a lot of people there that are mildly interested, or there for prestige or wealth, who are non-contributing.

This board of directors thing is a field in which there are published articles, associations, meetings, and so forth. But when you have a $4 billion company hanging in the balance, plus patients' welfare or staff's welfare, it is not an unimportant matter.

Protective Board Mechanisms

Hughes: Are there board formats that should be specific to certain industries?

Gumbiner: I do not know. That is a good question, totally unexplored as far as I know. So far, the format seems confined to corporate protection. We organized the FHP board in Delaware because you can't have a staggered board in California; your board has to be elected all at once, which provides a greater chance for a takeover. In Delaware, you can stagger your board so that a third gets elected every year, with a three-year term.

There is a difference between states on cumulated voting and non-cumulated voting. It is rather technical, but what it really boils down to is, you can vote all of your shares for all

of the seats on the board. In other words, if you have 40 percent of the shares, you could vote 40 percent for A, 40 percent for B, 40 percent for C. In the other instance, you vote for 40 percent across the board. These strategies are to prevent takeovers where somebody can try to get control of the board and subsequently the company by acquiring a majority of the shares and electing a majority of the board members. What Anderson did was much cheaper for him, because he did not have to buy controlling shares.

Other protective mechanisms have been created. For instance, if someone acquires five percent of the shares of a public company, they have to file a special form that alerts the company and everybody else that you may be in a position to attempt a takeover. Conversely, there is no filing or warning for a back-door takeover. Anderson did not file anything saying that he was attempting to get control of the FHP board and the company.

It is one thing to retire as CEO and become chairman, but then how do you get out of being chairman? You're not going to sit there and be chairman until you're ninety-five years old or die at your desk. You should have a definite plan for eventually getting out altogether. If you don't make a definite plan, you are going to end up like I did--losing the company.

There should be a plan to replace chairmen, i.e., bring in a replacement who is given a certain [trial] time period and goals. If he does not measure up, then he is out and somebody else is brought in with a scheduled evaluation and time period. The board should be in agreement with this, and the chairman should expect to have to step back in for a few months while the company is doing a CEO search, or their senior staff should be strong enough to run the company while they are doing the search.

Resignation Statement

Hughes: On June 22, 1995, the day after you wrote that long memo, you resigned, and you issued what you said in a later document was a carefully prepared statement based on consultation with your lawyers.[1]

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[1]Robert Gumbiner to Jack Anderson, chairman FHP, Int., June 22, 1995; "Chronology of Back-door Takeover of FHP Int[ernational] by TakeCare (Purchased by FHP)," August 4, 1995.

Gumbiner: There was a [press] statement, which I am sure you saw.[1]

Hughes: Yes. Do you remember your thinking in the way you worded your press statement?

Gumbiner: The thinking was pretty obvious. First, I sought legal counsel to find out what I could do about this [forced resignation], and they told me I could not do much about it. Frankly, I had a series of bad legal advisors. They could have told me I could have mounted a proxy fight before the annual meeting, which I later found out.

I said to the attorneys, "You know, I think that the board is going to disrupt this company so badly that the board of directors is probably going to get sued. I do not want to be on that board, first of all because of my questionable health, secondly, I do not want be involved in all of the stress, time, and energy in fighting this board, and third, I do not want the legal and moral responsibility." I did not agree with the amoral firing of loyal people and the destruction of the management team we had built for [corporate] growth.

So the reason we carefully prepared that statement was so that I could say what I wanted to say without any legal repercussions.

Hughes: And there weren't any?

Gumbiner: That is correct.

Hughes: How do you explain that? The stockholders could have protested.

Gumbiner: What would they protest about? They wanted their stock to go up.

There was an interesting article written by a Salomon Brothers' analyst [Robert Hoehn], who said getting rid of the staff model and selling the hospitals was a bold move, but will it work?[2] And that is essentially what the shareholders were doing; they were waiting to see if it would work. Most shareholders or fund managers do not understand the [HMO] business, so they do not know that when you remove the

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[1]Robert Gumbiner, KCSA News, June 22, 1995. See appendix.

[2]Salomon Brothers, "FHP International--Restructuring for Consolidation." United States Equity Research, Health Services, October 17, 1995.

hospitals, the staff model will not work well. When you remove the staff model, the IPA will not work as well. Management of a successful HMO is very far from their knowledge base.

The Question of a Proxy Fight

Hughes: You and Burke [Gumbiner], in August of 1995, met with three attorneys to talk over whether you should engage in a proxy fight.

Gumbiner: At that time, I was still suffering from complications of surgery and infection. These attorneys told us that we would have to do an East Coast road show which would be time-consuming and stressful, so I made the decision not to do that. Of course, that was bad advice, because we could have sent in a slate any time prior to sixty days before the annual meeting and not sooner than 100 days.

They should have advised us to submit a slate of who we felt were trustworthy people. We could have subsequently decided whether to pursue the proxy battle. Instead of doing the road show, we could have sent television tapes on our position to people. We could have created a grassroots program from the consumers and employees who felt strongly about it to send to institutional investors.

My other advice to the reader is to not just take one attorney's opinion on things like this. Get multiple opinions, just like doctors encourage you to get second opinions before going in for major surgery. Yet people like myself go to one attorney or one law firm and take their advice as gospel. Based upon that brief half-hour or hour visit, we made a decision which was probably a bad decision.

Probably if I had waged a proxy fight, I would have at least shown people that I cared about the company and I was trying to get control back. Even if I lost, it would have been better. Plus it might have frightened a couple of the board members that were waffling, the Prevratils and the Heinemans of the world.

When [Carl] Karcher--I talked to his lawyer--went back to Carl's Jr. and threatened a proxy fight, a couple of the board members changed their votes because they did not want to get involved in that, and he was able to put a surrogate [chairman] in. In other words, he did not regain the chairmanship, but he

had the financial guy that was bailing him out of his personal financial problems become the chairman but kept Carl Karcher's philosophy and policy. That's a middle ground. You can bring somebody else in as chairman, but on the provision that they are going to continue your philosophies.

Physician Management Company versus Staff Model Care

Hughes: In June, 1995, FHP began major restructuring, which we have talked about on and off through these discussions, but let's go through the points of restructuring sequentially, starting with the new physician management company, which originally was supposed to be called Compucare and then was later renamed the Talbert Medical Group.

Gumbiner: A physician management company has long been the dream of Jack Massimino, because he has always tried to figure out how he can personally get his hands on more money.

When we first capitalized FHP back in the early eighties, the board of directors wanted me to put up all of the money--I think it was perhaps $1 million. I did not want to do that because I felt that that would, first of all, not look very good, and second of all, I felt that everybody who had worked hard to put the company together during the twenty years it was not-for-profit should share in the future ownership.

So it ended up that I bought half of the shares, and the other half of the shares was offered to anybody who was a medical director or senior manager. There were about seventeen or eighteen of these people. At that time, they all bought into the company at a low cost per share. They were fully vested in two years after we converted. Later when the company went public, a certain number of them sold their stock and left. I thought that they would stick around to help build the company, but I was mistaken; many were shortsighted.

All of the managers who came in after that were what I call the "have-nots," and all of the seventeen or eighteen managers that were there were the "haves". The "haves" each had anywhere from $4 to $6 or $8 million worth of stock, and this caused jealousy from managers who came later but were the "have nots".

Jack Massimino had left us years ago for a better offer from a hospital consultant company, taking with him our HMO seat

on the Certificate of Need board in Utah.[1] He had been my assistant for a couple of years. Then I assigned him to manage Utah where he spent two years. Then he left us because someone offered him a little bit more money. So he is the kind of person that is always looking for more money. He ended up as a "have not" when he came back to the company.

Massimino was trying to figure out how he could get hold of some quick money. His plan, which I had heard of way before he thought of it, was to spin off the staff model into an old-fashioned medical group, take it public, and then get his hands on a percentage of that stock and sell it, so that he could make several million dollars. That was his objective. So I was not surprised when he used Price and Anderson to help make that happen.

Anderson wanted to get rid of the staff model because it was management intensive, he did not know how to run it, and it was costly to acquire facilities. He did not know that it was the stabilizing influence that allowed the HMO to provide quality and availability [of health care]. The staff model/IPA combination allowed FHP to get ahead of the competition. He just wanted to sell it and then sell the membership to another HMO.

Hughes: What about the criticism of the staff model, that there are a lot of fixed costs and it's better to contract out?

Gumbiner: You cannot get quality; you cannot control access and cost when you are contracting out. You only can contract with the doctors you have in the community; you cannot get them to work, and you cannot get them to turn out quality work. Most importantly, you do not build a delivery system with just an IPA because there is not the capacity in the provider system to grow. Besides, someone has to "pay the piper". How can an outside medical group supply services any cheaper than your own medical group? They have to manage and pay personnel also. This does not make sense.

Hughes: And is that what you said to that criticism?

Gumbiner: Right. I said the IPA is totally unstable unless you have a staff model along with an IPA. We'll discuss it more, because it is important. My opposition kept trying to characterize me as wanting to hold on only to the staff-model provider mode when

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[1]See Massimino's oral history bound with Gumbiner oral history I.

I actually had moved on to the combined staff/IPA model; the staff model to insure the IPA's success.

I had said, "You are not going to spin off the staff model." Price and Massimino could hardly wait to get Anderson in and get me out of there so they could take off and maybe grab that part of the company and stuff it in their pockets. That is exactly why it was done. It was not done because it was hard to run or anything else, because if it was not worth anything, they would not want it. So what they are going to do is destroy FHP. Part of this was by firing the hospital-based doctors.

For instance, we had a system in our hospital where salaried nurse-midwives were on the OB [obstetrics] floors at all times. The nurse-midwives delivered all of the normal babies, but there was always a doctor, an OB/GYN [obstetrician-gynecologist] specialist, on duty on the floor twenty-four hours a day. Now they have fired all of the nurse-midwives and there is no doctor on the floor. So if a woman ready to deliver comes in, they have to find a doctor, just like the old-fashioned fee-for-service. I would have lost my granddaughter if that had been the situation, because they had to do a [Caesarian] section in ten minutes because the baby's heart rate went bad.

Hughes: That's a cost-cutting maneuver?

Gumbiner: Short-term, they get rid of the nurse-midwives' salaries, but it is more expensive in the long term, because now they have to have OB/GYN doctors deliver all of the babies. Probably there was pressure from the doctors to protect their income.

I will give you another example. We used nurse-anesthetists for all routine cases, supervised by an anesthesiologist. That way we got along with, say, three anesthesiologists and six nurse-anesthetists. They fired all of the nurse-anesthetists, so now they have to have six high-cost anesthesiologists. Does that make any sense? They think they will only employ the anesthesiologists when we have a case for them, sort of fee-for-service. The nurse-anesthetists we had were on salary. That does not make any sense in any volume operation, and it is inferior care.

But see, other hospitals would not allow us to use nurse-anesthetists or nurse-midwives. So now you cannot have anything innovative because it is not allowed by outside-controlled hospitals. You cannot put your nurse-anesthetists or your nurse-midwives into somebody else's hospital.

So let's go back to the question. Probably the most valuable asset of FHP was its staff model--the most difficult to construct, but the most valuable asset. And if run right, it could do the best financially and provide the best care. But since current management does not understand how to run it and they do not have the capability, what they are trying to do is to spin it off, take it public and then sell it and steal some of the stock. Or they would like to sell it to somebody else, put the money in their pocket, if management can get their hands on 10 or 20 percent of the stock for free.

Hughes: Sell the staff model, or sell FHP?

Gumbiner: Sell the staff-model company which has been separated from the parent FHP company.

Hughes: Have the physicians, nurses, and others who have chosen to stay been transferred into this independent medical group?

Gumbiner: They are literally working for that outfit.

Hughes: How do they feel about that?

Gumbiner: They do not like it very well, I can tell you that.

Hughes: Why?

Gumbiner: They do not like the leadership, because the management thinks that they are dealing with a commodity. They want them to see twice as many patients. They do not give them the necessary expensive equipment to work with.

Hughes: Does it indeed mean that the medical groups contract out to virtually any sort of health plan which happens to want them?

Gumbiner: They think that they can sell their services to other HMOs. I do not think that that is going to happen because I do not think other HMOs are going to contract with a competitor, i.e. if the medical group is owned 80 percent by FHP, a competitive HMO.

Hughes: So with whom does the medical group contract?

Gumbiner: They are still contracting with FHP.

Hughes: But that's not really the vision, is it?

Gumbiner: That is not their idea. Their idea is to phony up the books to make it look like they are making money and then sell the staff model. Remember, the people now running FHP are not builders;

they are predators; they are sellers. They are selling off the carcass. They are going to sell a leg here, an arm there, a head over here, and so forth.

Hughes: You maintain that this is reversion to a model which you believe was proved long ago not to work?

Gumbiner: That's right. I have been there and done that. First I tried developing a medical group, fee-for-service. That did not work. The doctors all fought over the spoils. Then I tried a group practice, prepayment that was a staff model. I tried a medical group that contracted with an HMO, and it was essentially a fee-for-service medical group. That did not work. That was destroyed in a big blow-up in 1966 and turned into a staff model HMO where everybody worked for the HMO.[1] We were all working for the same goal. That worked well!

We then tried an IPA model in Guam that worked reasonably well, since we controlled it with our staff model. We were practically forced into that. Then we started an IPA in San Pedro. It ended up in 1990 when I retired with about 60 or 70 percent of the FHP service in IPAs, backed up with the staff model. The IPA was easier for a salesman to sell because it was nothing new and different. The IPA just used the existing doctors, never mind that they may have been incompetent, had no license, or were of the wrong specialty.

I will give you an example. In Utah they did not bill something like $3 million in services because they did not know how to bill. They just did not put it down in the billing. Somebody went over there and found it.

Hughes: What do you mean, they didn't know how to bill?

Gumbiner: They just did not know how to bill it.

Hughes: That doesn't make sense to me.

Gumbiner: Why doesn't it make sense to you?

Hughes: Well, how can a business group not bill for the services it provided?

Gumbiner: Because the service is provided by doctors and nurses and other providers who are not trained in billing and have no interest. A patient walks in the door who is covered by another insurance.

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[1]For more on the evolution of FHP, see Gumbiner oral history I.

But the wife is covered by FHP, so they just say, "Your wife is an FHP member?" They just charge it off to FHP when it is the other insurance that should have paid. The average fee-for-service hospital charges you for every little thing, right? They do not do that at FHP. They just say, "Here, take some medication, take a few catheters, take some blankets home." No charge is even written up.

That reminds me of when I was in Guam. Our manager needed some rubber heels for casts for our medical center. I was with her. So she went up to the government hospital and said, "I need some heels for casts." An employee said, "Here's a bag full." He did not charge her; he just gave them to her. She said, "Do you have any left?" "No." He gave her all of his heels for casts. He was not getting another shipment until the next boat came in. I was at FHP and the nurse said, "Here, you are cold; take the blanket home."

Mark Hacken set up a disposable medical equipment program because we were being stolen blind by contracting out. The outside medical equipment company was charging us for equipment, i.e. beds, etc., for people who had been dead for six months. When we canceled that company we found medical equipment we were paying for that didn't even exist.

As an example, I needed an IV pole when I was sick. They brought the IV pole out, but they never picked it up again. With poor management, FHP purchased $3 million worth of medical equipment--$1 million disappeared during the first six weeks. It was either stolen, given away, left someplace, or whatever. It was a good idea to provide and lease our own equipment, but it was not executed correctly.

A well-managed hospital will charge you for every Band-Aid, injection, et cetera. They do not do that at FHP. They do not know how to do that. They have never done it. They do not bill because they are set up for everything prepaid.

It is the same thing if you take care of every deadbeat that walks in the door. That is a big problem with fee-for-service, because people walk in, "That's going to be $150." "Oh, bill it to my insurance company, Doctor." "How do I know you have an insurance?" "Well, you can check on Monday." (This is Friday night or Saturday.) You check Monday; the guy does not work there [at the specified company]; he does not have insurance; he never had that insurance, or there is a $1000 deductible. He used to work there a year ago. Try to get paid after the service!

Hughes: There's also a culture clash: physicians, nurses, and other health professionals have presumably come to FHP because they either initially or as time goes on agree with the FHP prepaid philosophy.

Gumbiner: You put your finger exactly on it. Most of the physicians that came to FHP were recruited because they were tired of trying to run a business plus practice medicine. How are you going to tell them, "We want you to speed up and see more patients, and pay attention to every nickel and dime, be a bean counter"?

I hate to say it, but in a fee-for-service practice, you only treat people who can pay, because if you continue to treat people who cannot pay, you cannot pay your rent. Not only that, you throw in a few extra tests, because that is quality care, right? You are being very careful, so you run extra tests or do an extra procedure or have them come back two or three times for re-check, which you do not need to do.

The physicians practicing at FHP can take more time with the patient, but they do not have to have them come back two or three times to build up the bill or sell them the procedure that they do not need, et cetera. If you have a doctor that is avaricious and wants to make money, he would never join FHP, right? He would open up an office; he would sign up with every HMO, and he would rush patients through, billing as much as possible.

I have seen fee-for-services practices. I saw one belonging to an ENT [ear, nose, and throat] man who was seeing a patient every five minutes. You talk about running people through: the fee-for-service doctors are the ones that run them through, because they have to, or they do not make any money. The doctors who are working for a salary, why should they rush anybody through? You cannot make them do it either, because they will say, "I can only see this many patients."

Hughes: Are there not quotas? Kaiser physicians, at least on the books, are expected to see a certain number of patients per hour, the number depending on their specialty. Was that not true at FHP?

Gumbiner: Well, we know that a general practitioner ought to see twenty-five or thirty patients a day. But as a general practitioner I know the business; I can beat that easy. You know what I would do? I would have all the little old ladies and men with hypertension who were not sick come in, and I would take their blood pressure, and have the kids that had an earache come back two or three times, and on and on. Have a nurse check blood-pressure, and the patient is in and out of there in five

minutes. That is the way I would see a lot of patients in a short time with no effort and refer the time-consuming patients to specialists.

The general answer to your question is that you must have overall production standards and guidelines. After all, it is poor care to allow a surgeon to take six hours for a procedure that should take one and a half hours. Something is wrong.

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Gumbiner: Trying to do fee-for-service and prepayment at the same time is not successful because here is the patient that walks in and he is fee-for-service. Now you have to try to build the bill up and get as much money out of the visit as possible. Here is another patient that comes in who is prepaid, and you do not have to do that. So the doctor gets a little confused after a while.

Hughes: You have the same situation in the Talbert Medical Group. You are asking doctors to function in both roles, i.e., maximize the bill in one instance and not in the other.

Gumbiner: Exactly, because they think they are going to get fee-for-service patients off the street. They do not know how to bill and collect. They are not set up to check their insurance and manage coordinating insurance. The people that come in from the other health plans are not necessarily on capitation; we used to pay the IPA doctors on a fee-for-service basis, up to a maximum. The more fees they billed, the bigger their portion was of the percentage of premiums. So they were going to have to bill carefully for everything.

Some of the doctors do not want to do that. Within fifteen minutes they have to meet the patient, establish rapport, examine him, make a diagnosis, and prescribe a medication. That is a lot. And then you want them to try to keep track of all of the billing? Forget it. They will not do that. They will not put down a consultation. They will just put down a regular office call. That is what is going to happen.

And since their administration is not set up to make sure that everybody has insurance and to collect the 20 percent for the people who have a co-payment, they are not going to get that either. They are not going to collect the co-payment or the deductibles. It's going to be a disaster.

Elimination of FHP Hospitals

Hughes: Well another aspect of FHP restructuring was to get rid of the FHP hospitals. I know you have thoughts on that subject.

Gumbiner: All I can say is, you cannot deliver a complete health care program without integrating all of the aspects of care, the doctors, hospital, and pharmacy. Without a hospital, the managed-care system loses efficiency, control of quality, and the ability to initiate innovative cost-saving and quality systems. It is at the mercy of the outside hospital's profit making, inefficiency, and different objectives.

Hughes: As part of your philosophy about vertical integration--

Gumbiner: That is not a new philosophy.

Hughes: I know it's not. But FHP leadership's new scheme is not new either.

Gumbiner: They are doing exactly the opposite of our long-term policy of vertical integration. They are "out-sourcing"--that's the new buzzword. When you out-source, you can not keep control.

I will give you an example. My former wife [Josephine "Dodie"] had a stroke. The medics picked her up and took her over to St. Mary's Hospital. I called up FHP and said, "Look, I want a life-support ambulance out here and I want them to move her to the FHP facility." It is a better facility. You know how long it took a contract ambulance company to get a life-support ambulance out? An hour and a half! So I said, "What the hell is wrong with you people?" The ambulance company said, "Well, we had to go find an intensive-care nurse, and we had to go to her house; she had to get dressed; we had to pick her up." I said, "By that time, you don't need an intensive-care nurse. The patient is dead!" So I said, "Forget it, FHP can't use your service."

That was our fourth or fifth ambulance service. They do not train their ambulance people right. After that, if we wanted a life-support ambulance, it came out of our hospital. A nurse from intensive care walked down the stairs and got aboard. That was it!

Hughes: It is the conflict that keeps coming up: Between what you consider good medicine, and what your opponents consider economizing by contracting out.

Gumbiner: That is true, but what if you were the patient, the consumer, the customer, and your mother, wife, or husband had to wait an hour and a half for a life-support ambulance?

Hughes: Oh, I would be incensed.

Gumbiner: That's right. You would change health plans, wouldn't you?

Hughes: Yes.

Gumbiner: So there is a business reason for it. If you had to go into a hospital that is dirty, ugly, the food is terrible, and the service is poor, you do not care how sterile the surgery is if everything is wrong.

I went down to Houston, Texas to have some cancer surgery done about a year ago. They were using a contract hospital. I would never go back there. I do not care how good the surgeon is. I selected the surgeon because he had the largest series of cases of that particular surgery in the country. You can imagine, I got a private room. It was noisy; they kept the door open and kept on the light. When I came out of anesthesia, they served me spaghetti and meat sauce for my dinner. Can you believe that? So you know what I did the next day?

Hughes: You checked out.

Gumbiner: I checked out, and I checked into a suite at the Ritz Carlton, and I ordered room service and had a nice bowl of chicken soup with a rose on the table. This suite cost me about $280 a night, and the hospital was costing me $1,100 a day. I was much happier.

But if you go to the average hospital, you will find that their food tastes terrible. I hired a chef at our hospital to direct the food service, and I was constantly unhappy. I used to watch the trays come back. If the trays came back full of food, I would have a word with the food service manager because the trays should not come back full of food. Either they are giving them the wrong foods, or it is poorly prepared, or there is too much of it. Why can't they give a post-op [post-operative] patient a bowl of chicken soup, right?

Hughes: Sounds reasonable to me.

Opening FHP Facilities to Non-FHP Members

Hughes: One of the things that happened with this restructuring was that FHP facilities were supposed to now be open to non-FHP members. Isn't that illegal? I thought that there was a state or a federal regulation that restricted FHP facilities to FHP members.

Gumbiner: Not if they become an independent medical group.

Hughes: Did non-FHP members use its services?

Gumbiner: I don't know who would walk in there except a deadbeat who did not pay the other doctors in the community. It is a good place to go--the FHP center, now the Talbert Medical Group. You can get in there and they will treat you for free.

You see, the whole idea of prepaid group practice is very simple. All members have to do is present an FHP card and they run it through the little machine and it tells you if they are a paid-up member. That's it. Bingo! They pay the three dollars or whatever it is, and they get all the service they need. It has already been paid for. You do not have to collect or worry about people not paying. And that is why FHP medical group culture is not going to be successful in fee-for-service. Fee-for-service is very complicated to make successful. They have to make sure everybody can pay and their insurance is good, that there is not a deductible or co-payment they should be paying, and so forth.

Medicine and Money

Hughes: Also, people like you, who combine medical training and business acumen, are a rare breed. The average physician is notorious for being a poor business manager.

Gumbiner: Physicians should not be in business. It is too complicated.

When I began to practice [1948], there was no medical insurance, if you can believe that. A patient walked into my office and I had to get paid to make a living. In other words, I had to keep training my front office personnel to say, "That will be X dollars." Not to say, "Would you like to pay?" Of course they wouldn't like to pay.

There are always people who say, "Well, Doc, I just went through personal bankruptcy. I guess that makes us even, and I can start coming back in again [for your medical services]." I said, "No you can't." Then you have all of these horror stories about fee-for-service with people saying, "We are not delivering your baby here unless you pay first." But then a woman appears with the baby's head on the perinaeum; she has no money; they had to deliver her, right? And she never pays them.

I guess what I am talking about is I am not too sure that shareholders' return should be the major element that we address in a medical establishment. Perhaps managed care should be like a utility: the shareholder gets a certain return and that is it, period. They are not going to get 100 times their investment as with computer stocks. Health care should not be in that marketplace. There are too many ways you can squeeze it.

For instance, patients do not know what [care] they should get and what they should not get. They are depending upon the doctor to be the purchaser of care for them. And you do not want the doctor to be motivated by only financial interests. The shareholders' concept of the best return for themselves puts a squeeze on the providers, and these attitudes all filter down.

Hughes: If medicine turns into an investor-controlled profession, you are not going to get the same sort of person going into medicine.

Gumbiner: Well, the people going into medicine now do not know what is going on in reality. You have more applications for medical school positions now than you ever had. Maybe I should lecture to medical students. On the other hand, it's a dilemma. If you were to say, "We need a better system; we cannot go on with the old fee-for-service cottage industry--"

Hughes: Well, that's dead.

Gumbiner: Well, maybe it's dead, all right, but it is not that dead in some of these small towns in middle America. And then you say, "Well now, if that's true, we cannot go along with that. We have to have some type of organized or managed care." The whole idea is that the name "managed care" means you manage care.

Anderson is not interested in management; he wants to get rid of management. He fired most of the management. He is not interested in good health care, effective delivery of care, or growth and innovation. His main objective is to get rid of every full-time-equivalent employee he can. But if you do that you do not have management and you no longer have managed care.

So it follows that to increase the shareholders' return, he is going to destroy management and work with as little management as possible. In order to increase the shareholders' return, you are going to take as much out of the provider's pocket as you can, resulting in poor morale and poor service.

I am not saying that we cannot take it out of the provider's pocket in the U.S.A., because we have the best-paid providers in the world. However, most people going into medical school now I think are going in for reasonably altruistic reasons, but I bet they feel that they will have a secure livelihood for the rest of their lives--they think. They may think wrong.

Interestingly enough, for the first time this year, the entering class at Harvard was over 50 percent women. Now, what that has to do with it is only left to conjecture, because I think that you get fewer working years out of a female doctor than a male doctor, because many women take off time to have children. Most of the women doctors I know have dropped out from time to time to take care of their kids or family. They have a tendency to go into less time-consuming specialities, like dermatology and ophthalmology, or to work for organizations that allow them regular hours or more time off. Perhaps they will be less financially demanding.

If you were to look into it and say, "What percentage of doctors today are care-givers?"

Hughes: What do you mean by that? Primary care?

Gumbiner: No, <u>care-givers</u>. Care-givers who want to give care to people. Well, of the doctors I know, maybe 20 percent at the most are true care-givers. The other 80 percent are what I call techno-scientists. They are in health care because it is scientific. The type of people that get into medical school make high grades in undergraduate school, right? These days you have to have a 3.5 to a 4.0 [grade point average] to get into a medical school. What kind of people are those? Are they the type that are well-rounded, that are out amongst the folks? Probably not.

Hughes: I take your point, but the current move towards primary-care specialists appears to counter that trend. My understanding is that there are state-mandated quotas--certainly in California--so that a medical school with state financial backing has a quota by department for how many specialists in a given field can be turned out. And the number is declining in non-primary-care specialties. Yet a primary-care specialty may be encouraged to turn out twice the number of specialists.

Gumbiner: Well, this is all very philosophical and has to do with the problem of what part the investor-controlled HMO provider should pay. This could include hospital chains, some of which are buying medical schools; it could be HMOs buying medical schools; it could be a number of other entities. The question is, will the publicly traded HMOs contribute to the community by supporting education and research?

Hughes: How does a founder and long-term director make allowances for changes in history? The environment when you began this company in the early sixties is very different from that in the mid-nineties.

Gumbiner: We moved with the times and changed from a staff model to a mixed model with the majority of our business being in the IPA. I think the one thing that I did not count on was how the financial environment changed. The public HMOs are investor-driven and not medical provider-driven. The environment had changed from the evolution of the socially conscious, achievement-oriented health plan into the money-driven, materialistic, short-sighted, greedy investor-oriented organization.

Now, that can happen in many other industries; you expect that in industries where profit is the driving motive. But you do not expect it in the HMO field, because there are still a lot of not-for-profit HMOs and people who are interested in the mission to deliver the most care to the most people for the least amount of money and to improve the quality and availability of health care.

Hughes: Were those the aims of the majority of FHP personnel?

Gumbiner: I think so. I do not think that the majority of people I hired were there just to see how much money they could make. We prided ourselves in having more care-givers amongst our providers than you find in the fee-for-service sector. As a whole, our people could concentrate on being care-givers because they did not have to worry about running an office or meeting their bills or all these other things that the fee-for-service doctors have to do.

Robert Gumbiner's Burnout and Ill Health

[Interview 3: February 14, 1996] ##

Gumbiner: Let's talk about the emotional aspects of this takeover. This can include a burned-out or disinterested CEO/chairman who resents all of the work and hassles and the political maneuvering. This will show to the board of directors and staff.

On the other hand, if he or she is too successful and is dealing with board members that are not that successful in their own right, then you have jealousy and envy on their part that plays into it. How much it plays into it, no one knows. People do many things [for emotional or subconscious reasons]. They do not particularly do them on a logical basis. Why would my two long-time board members, for instance, decide that they would prefer to have leadership come from a company we acquired and paid a premium for and they knew nothing about? They could be the laughingstock of the industry. They had to have a reason. And the reason probably was not fully monetary, although they were rewarded handsomely with company money for their vote.

I think that the chairman has to pay attention to the emotional content of a situation where you may make people envious and jealous because you are too successful; you may make them angry because you are not paying attention to them or you don't seek or take their advice; or you may get them annoyed by perhaps coming to a meeting late. The chairman may be acting in a self-defeating manner in regard to the board and its support.

If you are a student of human behavior, you say, "Why would a chairman do that?" Somebody might do that because he did not want to be chairman any more and could not figure out how to leave gracefully. So he gets the job done by acting in such a way that his board members either become angry with him or hook up with someone else to get even.

I think when a founder/CEO retires, his major plan, thrust, and concentration should be on finding someone or a system or structure that will carry on the organization in the manner that made it successful, instead of just hoping that a successor will get the job done.

Hughes: I am wondering how much burnout was a factor in the case of Robert Gumbiner. You had been doing this for decades.

Gumbiner: That was a major factor. My message to people who find themselves in the same position is that they should have a definite plan and timing of how they are going to replace themselves. Do not just drift forever. The other thing that played a part was my surgery and problems that I had with prostate cancer.

Hughes: What you are saying is that surgery was a complication, but there were problems that predated that, namely, burnout and the fact that your life was no longer totally focused on the company.

Gumbiner: That's true. And I had other personal distractions. Nevertheless, I think that if the founder and CEO wants his vision to continue, he should make plans to make that happen.

Doctor-Managers

Hughes: What difference do you think it made that the people making the decisions, the executives (with the exception of you), were not M.D.s, and, I understand, there was no mechanism for physicians and the nursing staff to have a direct imprint on policy?

Gumbiner: That is not exactly true. We had been training doctor-managers for years, and some had important general management positions. One was in charge of [the program in] San Diego and another of northern California. I think that the lack of more doctor-managers was a significant problem in senior management. Also, I did not recognize the lack of doctors in board of directors representation. I was into the management theory that doctors practice medicine and managers manage, and that management would not try to practice medicine and doctors would not try to manage.

Somewhere along the line, I think there should have been more input by the providers. It could have saved the company and maintained the FHP mission which is, deliver care in a new, innovative, creative fashion on an economically sound basis. More expansion of management-trained doctors probably would have helped, but it is always a disaster to let management-naive doctors take charge.

After this takeover and with the accent solely on shareholders' and investors' interests, the whole idea of delivering care to the most people for the least amount of money was totally obviated and scrambled to create more shareholders'

wealth. What you have to watch out for is the type of management people that you bring aboard. People you are going to attract to a for-profit public company can well be people who are more interested in increasing their own personal wealth than they are in building and achieving.

Hughes: People from a business orientation don't necessarily understand medical philosophy. Whether they are looking for personal grandisement or not, the philosophies in business and medicine are different.

Gumbiner: I doubt that greed is limited to businessmen--there are plenty of greedy doctors. Self-centered, greedy people come from all fields and walks of life. Take the entertainment industry. Some of these folks are multi-multi-millionaires, even billionaires, and yet they work like dogs. For instance, Michael Eisner, who is head of Disney, is very, very wealthy. He had a triple cardiac bypass last year. But he is a workaholic. He is hyperactive, over-committed. Why would somebody do that? They are obviously not doing it for money. They have all the money they need. They are doing it for personal accomplishment and achievement and all of the perks they get, psychic income.

Hughes: What I was trying to get at is the clash of cultures: medical culture not being completely in sync with business culture.

Gumbiner: Well, let's put it another way. I do not think medical culture is necessarily altruistic, nor is business culture necessarily non-altruistic. You have businesses that are socially conscious in that they take care of their employees and produce a profit at the same time. There are doctors who are self-centered and focused on their own personal financial gain.

But I think there is a greater probability of profitability if you meld into management the right folks from the provider group. At least they understand what you are trying to do and the difficulty of trying to do it. You cannot have somebody manage the staff-model medical group that has never worked with patients on the floor. They do not have a clue of how and why systems work. If management says, "Well, we are going to increase the doctors' load from twenty-five patients a day to thirty-five," they do not understand if you do that to a doctor, he will just churn. In other words, he will have his old patients come back; he will introduce himself and establish rapport, find out what is wrong with them, send the sick ones off to another specialist, and just churn [his not-so-sick patients]. His dance card will look just fine; it will be all filled up, but not productively.

Hughes: Isn't that a danger with the way health care is going?

Gumbiner: If you leave it totally up to the doctors or the providers, you have a good chance of not getting much productivity. Doctors are notoriously poor managers and visionaries. Take the Swedish system for example: Several years ago, they managed to get the Swedish doctors to all agree to work for the federal government in return for extra time off and postgraduate work. Well, the last time I talked to the Swedish planners, they were complaining that they cannot get productivity out of the doctors. How are you going to get productivity from people who are only working about nine months out of the year?

I learned long ago that you can't have a psychiatrist or psychiatric social worker making their own appointments when they are working for a salary. They will make appointments with people that are not very difficult cases. They can sit there and schmooze with them. But just try to get them to do two group sessions a day. With some exceptions, they do not want to do that. They want to sit down and play Dr. Freud one-to-one and take a nap.

One time I had the doctors making their own appointments. Well, they would arrange for no appointments after four o'clock in the afternoon, or they would say, "All of my cases are very hard," so they would only see two patients in an hour. One guy was in the back playing chess with himself with an automatic chess set. You have those situations! We had a dentist in Guam whom we had to let go, because if he had a cancellation he would take a nap instead of helping out other dentists whose schedules were overloaded.

I do not think one can be simplistic and say the answer is having the providers run things. But I think the answer certainly is not in having financial people totally in charge.

Hughes: What about a mechanism for these two groups to communicate on a regular and organized basis?

Gumbiner: Unfortunately, some of the management people are ruthless and more confrontational than the doctors, and they will intimidate the doctors by firing a few, like they did in this situation [with Talbert Medical Group]. They say, "Well, we want you to sign contracts with us as independent operators, and if you don't, we will fire you." These doctors say, "Wait a minute, if I get fired, I can't pay my mortgage." If they were confrontational, they would have formed a union and fought back, but they are not.

Probably one of my problems was that I was still a little naive and not ruthless enough, or I would have gotten rid of some of these troublemakers. If you kill the baby, it's not going to grow up to stab you.

The $23 Million Mistake

Hughes: I read of a $23 million mistake in California. What is that?

Gumbiner: Well, I wasn't too aware of that, because they tried to hide it. But they had a $23 million mistake in the way they handled something, and it appeared on the books in error as a charge against earnings. It really was in this guy Judd Jessup's shop, but he managed to spin it off and claim it was the problem of one of the FHP managers.

They, meaning Anderson, were attempting to fire as many FHP managers as they could. He said, "Oh, this woman has been working for us for sixteen or seventeen years. She made a big mistake here. I guess we will have to relieve her from her responsibilities. Anybody have an objection?" That's the way he worked. Burke [Gumbiner] said, "The chairman can't fire an employee who reports to someone else." So Anderson called in this guy Jessup--his stooge--and had him fire her. She claims that [the financial loss] wasn't her mistake.

Hughes: And that was the end of that?

Gumbiner: She's out! She was going to sue them for wrongful dismissal, but she ran out of money to pay attorneys.

The Need for Hospitals

Hughes: You said yesterday that it was erroneous to think that the majority of the board of directors should be outsiders.

Gumbiner: That's right. Even if the so-called outsiders look good on paper and they give you unbiased, objective opinions based on their experience in management, they still don't know the [HMO] industry. In other words, if you look at the numbers that Anderson and his gang [came up with], you see that the hospitals are not making the return that a similar investment could make in the IPA, so you would come to the conclusion to sell the

hospitals. On the other hand, they do not realize that the hospitals and the staff models are what every IPA operator would love to have because they could keep them competitive.

It's like insurance; the premiums do not make money, but you pay the premiums anyhow. In the year 2010 we are going to have 60 million Medicare people, not 37 million as we have today, and we have not built too many hospital beds in this country in the last twenty years. These extra 30 million people are not going to use just four times but probably six times the care that younger people use, because they are not just over sixty-five but in their eighties. They will be sicker and use more Medicare, and you will run out of hospital beds. If you do not have any hospital beds, the IPA cannot operate, because now they have to pay whatever the hospital wants to charge them, because the hospital will not make contracts with them.

The other thing they do not know is that I would say 50 percent of the hospitals in this country are obsolete. They have been around for fifty years and they should be replaced. They should be torn down and turned into something else, and new acute hospitals should be built. The acute hospital of the future will have mostly intensive-care beds and backed up by sub-acute hospitals. Subacute hospitals are a lot less expensive and you do not have to carry the burden of x-ray equipment, special procedure equipment, laboratory equipment, et cetera. All you are doing is supplying somebody in a bed with nursing care. The difference is the difference between a $1,100- to $1,500-a-day hospital bed in an acute hospital today and a $250-a-day hospital bed.

These people who took over FHP closed our subacute hospital, which was a concept that we had that was saving us a lot of money. Now it is going to cost them more money for hospital care, but they do not understand this! They say, "We've got extra beds in our acute hospital, so why should we have a subacute hospital? We will close it. We will put people in the acute hospital beds." Well, according to the marginal utility of money theory, for the acute hospital bed, that's true. If you have an empty bed and you stick somebody in there, you are just going to pay for their room and board. But sooner or later, those beds fill up. Now you are short. Now you have to find a place for these people. And you do not have your subacute hospital. So the HMO pays a premium for intensive-care beds where FHP doctors do not have staff privileges and have no control over treatment or costs. It's all a problem of short-range thinking against long-range thinking.

Hughes: Not just FHP hospitals but a lot of hospitals have empty beds. How does a company get past this present rough period where it can't fill up the beds?

Gumbiner: Well, you would never open up a hospital for an HMO with the idea that the beds would be full, because then you could not grow. You would have to build another hospital. I anticipated that we would build when our beds were 50 percent full. That was the whole idea: we would have a chance to grow. Now, if you owned a standard fee-for-service hospital, you would want to fill all of the beds. But if a hospital is part of a managed-care delivery system, what you want to do is give yourself a margin for growth, particularly if you are bringing in more Medicare patients, which use a lot more hospital care. Besides, the HMO is paid for hospital care whether it is used or not.

Hughes: And then you put your effort into growing.

Gumbiner: That is exactly what should have been done. The energy and time and money should have been put into marketing and growing, particularly in the Medicare section in northern California. But that did not happen because of the change in philosophy. FHP's new management is not interested in growing; it is interested in dismembering the company and selling the carcass. When you cut out staff, you can not grow; it prohibits you from growing.

Hughes: Some believe that with the trend towards cost-cutting and retrenchment, the incentive for growth is being lost.

Gumbiner: Exactly--growth, achievement, fun, excitement, getting up and going to work in the morning and enjoying it. If you go to work in the morning and you are just tapping sand in a rat hole and you could be fired in the next wave, if you are any good, you start looking for another job. And if you are not, you are terrorized and you do not get anything done.

IPAs

Hughes: Ed Keaney, who is an analyst at the investment banker and brokerage firm of Volpe, Welty and Company, has been quoted several times in articles concerning FHP. He said that the staff model in the sixties and seventies allowed health plan executives to better control costs by owning hospitals and employing M.D.s. Then he says, "But in the nineties, the information technology has advanced to the point that health

plans are able to exert a great deal of control over the behavior of physicians and hospitals without having to own them. I don't think Dr. Gumbiner is fully in recognition of that."[1]

Gumbiner: Not true. First of all he is no expert in health care management; he is just a financial analyst. If you run your lifestyle on the advice of an investment broker you will be in deep trouble. He is just wrong!

IPAs can control the behavior of hospitals as far as getting more favorable contracts for hospitals, but they are still not able to control the ambience, the physical plant, the bad emergency room, the bad food, the quality of care in general. And innovation--forget it!

We have threatened hospitals by removing people unless they make the food better or have a better emergency room and keep the place clean. They say, "Yes, we will do it." They do not have the ability to do it. That is the bottom line. They do not have the skilled management. They do not have the focus. Hospital administrators are notoriously poor managers, with a few exceptions, particularly in the not-for-profit field. What this analyst does not recognize is that you have to control all elements of a managed-care program in order to be successful, and if you don't, you cannot control it.

The End of Robert Gumbiner's Vision for FHP

Hughes: I think that a good place to end this long discussion would be your resolution about how to handle what you see as the destruction of your vision of FHP.

Gumbiner: I don't know if "handle" is the right term. I think that my advice to anybody else that this should happen to is: if you are going to do something about a takeover like this, you have to do it within about ninety days from the time it occurs. You can not let it go on for six months or a year. After that time, all you are going to regain if you take back control is a corpse. These takeover people only want to liquidate and are having a fire sale to destroy this company as fast as they can, so that somebody like myself could not come back in and recapture and rebuild it. I think that after six months to a year, no one can rescue it.

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[1]Norma Wagner. "FHP Founder Predicts Redesign Will Fail," Salt Lake Tribune, July 17, 1995, pp. F1-F2.

In my particular instance, my health was such that I felt that I could not mount a proxy fight or an attack within ninety days, which I would normally have done. One thing that gets my interest is a good fight, especially if I am on the side of right. I think that one has to try to figure out what your opponents' capacities are and what the cost will be in time, energy, and money. I would have liked to have recaptured this company and brought it back to growth and greatness, gotten rid of the people who were causing the problems, and replaced them with competent people who were achievement-oriented rather than predators bent on destruction and personal gain. However, I do not think you can do much about it after time has gone by.

Having said that, you do not have to let them get away with theft. In other words, I do not really have to let them get away with stealing part of this medical group from the shareholders. That is just wrong, management giving themselves 10 percent of the shareholders' $400 million assets for no investment.

Current Interests

Gumbiner: I think I will probably have to concentrate my life on recovering my health. Once I do that, I will probably go off in a different direction. Right now I am working on opening a Latin American museum of art.[1] In addition, I just opened up a restaurant, and I am doing a philanthropic program in health care for low-income people in Santa Ana.

Hughes: Do you want to expand a little on Santa Ana?

Gumbiner: I started the Santa Ana project when I was chairman of the FHP Foundation. It is an idea that is patterned somewhat after our Outer Island Dispensary System in Yap, that is, three to five very small medical centers that we can man with mid-level medical providers reporting to one physician. This would remove the barriers between the low-income person and the person providing health care because it is free, available, and accessible.

They are really health centers, not clinics, because our emphasis is on preventive care: immunization and well-baby care, family planning, maternal health. We will be doing stopgap medicine for people who have problems and also will act as an

[1]See appendix.

ombudsman until we find them a doctor and a hospital bed. You have to bring health care to the population; you cannot expect people to find their way into a sophisticated hospital or a distant clinic site. They do not have transportation and they do not know what is available or that they should seek help.

Hughes: How is that program underwritten?

Gumbiner: The foundation is underwriting it for about $1.5 million a year for three years. The trick is to watch your dollars and get maximum value.

Hughes: Are you overseeing that project?

Gumbiner: I am the chairman, but I have an executive director who is doing the day-to-day work. I am just there to give it some stimulus, guidance, and policy direction. It's not something I want to do because I would rather move completely out of the health care field for a while.

Hughes: When did you make the decision to get out of health care?

Gumbiner: It is something I have thought about recently. I think that I have been in health care too long, and given the circumstances of the last year or two, I think I would be better off in another field. It would be more interesting. Besides, there is too much money on the table in managed care today. This makes people act strangely and attracts the wrong people with the wrong motives into the field. I think the creative, fun cycle is about over. In the future I will only work with people I like. My feeling is if you can't have fun in whatever you are doing, whether it is organizational development, planning or operations, then you should not get out of bed in the morning.

My regrets are that I am not able to bring the medical-school concept into the HMO. No more accusing HMOs of second-rate doctors. This would have been the ultimate marketing project, the totally integrated health care system, from the training of doctors and other individual professionals, to the organization and delivery of preventative and corrective care, as well as the maintenance of physical, mental, and social health.

Hughes: Is that it?

Gumbiner: Yes!

Hughes: Thank you.

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AN INTERVIEW WITH NICK FRANKLIN

Interview Conducted by
Sally Smith Hughes
in 1996

Nick Franklin.

FHP
HEALTH CARE

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BIOGRAPHY

NICK FRANKLIN
Senior Vice President, Public Affairs

Nick Franklin is Senior Vice President, Public Affairs of FHP International Corporation, a diversified health care services company. Through its health maintenance organizations (HMOs), FHP provides prepaid health care to more than 2 million members in eleven states and the territory of Guam. FHP is one of the largest Medicare Risk contractors in the United States, serving more than 395,000 Medicare beneficiaries.

Mr. Franklin is responsible for federal, state, and local government affairs; public relations; community relations; grassroots political efforts; and FHP's Political Action Committee.

In addition to his FHP activities, Mr. Franklin is also a member and chairman of a number of key policy committees of the American Association of Health Plans (formerly GHAA/AMCRA) and the Coordinated Care Council. He is also a member of the Executive Committee of the Public Affairs Council, a national organization of public affairs professionals.

Before joining FHP, Mr. Franklin was President and co-founder of Southwest Public Affairs, Inc. and an attorney with the law firm of Sutin, Thayer and Browne, both based in Albuquerque, New Mexico, His clientele included FHP along with many other health care related organizations. His expertise in government and administrative law, government relations, and lobbying was developed over a 25-year period which included service as Chief Legislative Assistant and legal advisor to the Governor of New Mexico, Secretary of the Energy and Minerals Department of New Mexico, and Chairman of the Democratic Party of New Mexico. Mr. Franklin also served as an adjunct professor in the Graduate School of Public Administration at the University of New Mexico.

Mr. Franklin received his BA in Government from New Mexico State University and is a graduate of the George Washington University National Law Center where he received a Juris Doctor degree. He was admitted to the State Bar of New Mexico and the District of Columbia in 1969.

He and his wife, Susan, live in Newport Beach, California.

BIOGRAPHICAL DATA

Nick Franklin
SVP, Public Affairs
FHP International Corporation

EDUCATION:

Bachelor of Arts in Government
New Mexico State University
1965

Juris Doctorate
George Washington University
Washington, D.C.
1968

Certificate—Senior Manager Government Program
JFK School of Government
Harvard University
1994

PROFESSIONAL:

Senior Vice President, Public Affairs
FHP International Corporation
Fountain Valley, California
July 1993 to present

Vice President, Government Affairs
FHP, Inc.
A California based health maintenance
organization (NASDAQ)
1990 to July, 1993

President, Southwest Public Affairs, Inc.
A Lobbying and Government Relations Consulting Firm
Albuquerque, New Mexico
1989 to 1990

Attorney with Sutin, Thayer & Browne
A Professional Corporation
Albuquerque, New Mexico
1989 to 1990

Attorney/Partner with Franklin, Abernethy &
Hughes, P.C.—Specializing in Government
Relations/Administrative & Business Law
Albuquerque, New Mexico
1984 to 1989

STATE GOVERNMENT:

Secretary, Energy & Minerals Department
State of New Mexico
Santa Fe, New Mexico
1978

Administrative Assistant for Legislative
and Legal Affairs to Governor Jerry Apodaca
Santa Fe, New Mexico
1975 to 1978

Supervisor and Coordinator of Governor's
Program for the Reorganization of State
Government

Member, Governor's Energy Impact Task
Force

Member, New Mexico Border Commission

Secretary for Criminal Justice

Chairman, Criminal Justice Planning Council
(LEAA Program)

Chairman, Correction's Master Plan Steering
Committee

Member, Western Governor's Task Force on
Regional Organizations

Member, Staff Advisory Committee, Western Governor's
Conference

Governor's Staff Liaison to National Governor's Conference

OTHER EXPERIENCE:

Adjunct Professor in the Graduate School of Public
Administration, University of
New Mexico
1982 to 1983

Administrative Assistant to Vice President Washington Staff,
Ford Motor Company
Washington, D.C.
1966 to 1969

ORGANIZATIONS/ACTIVITIES/ HONORS:

Member, Government Affairs Council of the Group Health Association of America (GHAA)
1992 to 1994

Chairman, Public Affairs Committee of the American Managed Care and Review Association (AMCRA)
1992 to 1995

Chairman, Health Care Reform Task Force of AMCRA
1995 to present

Member, Health Policy Council of
The Center for the New West
1991 to 1994

Member, New Mexico Bar Association,
District of Columbia Bar Association and American Bar Association

State Chairman of the New Mexico Democratic Party
1981 to 1984

Vice President of the National Association of State Democratic Chairs
1982 to 1984

Member, Democratic National Committee
1981 to 1984

President (1987 to 1989), Executive Board of the Great Southwest Council, Boy Scouts of America
Executive Board: 1985 to 1990 (Eagle Scout & recipient of Silver Beaver Award)

Chairman, New Mexico State Racing Commission
Member of the Board, National Association of State Racing Commissioners
1985 to 1987

Member, Governor's Business Advisory Council
1987 to 1990

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BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name Robert N. Franklin (Nick)

Date of birth March 25, 1943 Birthplace Hobbs, New Mexico

Father's full name Robert E. Franklin

Occupation Plumber Birthplace Abilene, TX

Mother's full name Mary E. Franklin

Occupation Homemaker Birthplace Breckenride, TX

Your spouse Susan Bentley Franklin

Occupation Homemaker Birthplace Washington, D.C.

Your children Lisa K. Franklin; Nicole Franklin Morales

Where did you grow up? Las Cruces, New Mexico

Present community Newport Beach, CA

Education New Mexico State University, B.A., 1965

George Washington University National Law Center, J.D., 1968

Occupation(s) Senior Vice President, FHP International Corp., Health Care Plan Executive

Areas of expertise Public Affairs, Government Relations, Strategic Communications

Other interests or activities Politics, Antiques, Tennis and Skiing

Organizations in which you are active Executive Board, Public Affairs Council; Executive Committee, Orange County Boy Scout Council; Board of Directors, Democratic Foundation of Orange County

IV AN INTERVIEW WITH NICK FRANKLIN

Senior Vice President of Public Affairs, FHP, 1990-Present

[Date of Interview: July 3, 1996] ##[1]

Creation of the Position

Hughes: Mr. Franklin, please start with when and why you came to work with FHP.

Franklin: I came to FHP in the fall of 1990 in a new position called vice president of government affairs. Prior to that, I had represented FHP in New Mexico from a legislative standpoint as a lobbyist. I also helped with their Washington activities and with those of the other western states. At the time I had a law firm and we also did legal work for FHP.

Hughes: Do you know what prompted formation of a new position?

Franklin: FHP already had a small government affairs operation with a couple of people, but there was a growing recognition that a much larger legislative agenda was going to develop in the states and in Washington. FHP already had a D.C. office, but the corporation was growing and they realized that they needed someone who was experienced in coordinating all those functions.

Up until that time, Dr. Gumbiner was directly involved in those things himself. My position was created in the course of his retirement as CEO in November 1990.

Job Responsibilities

Hughes: Did you spend a fair amount of time in Sacramento and Washington?

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[1]## This symbol indicates that a tape or tape segment has begun or ended. A guide to the tapes follows the transcripts.

Franklin: I spent a lot of time in Washington, as well as in FHP's regions, which at the time included the states of California, Nevada, Utah, Arizona, and New Mexico, and the Territory of Guam. I did a lot of coordination with the individual states and the territory. We had lobbyists who represented us in the states, so I focused on coordinating their activities. I also spent a lot of time dealing with our Washington office and managing that function.

In addition, we were drawing together the disparate pieces of government relations which were not adequately coordinated at that time. There was a political action committee that had been operating in low gear, and we made a major effort to rev it up and put it into high gear and really make it significant. We also developed a grassroots program which became very effective. My charge was to create a strong, high-level comprehensive government relations program.

Hughes: Was this an action that many of the larger HMOs were taking?

Franklin: FHP was always ahead of its time in government affairs compared to other HMOs. Dr. Gumbiner had established the D.C. office at least ten or twelve years before I arrived. Other HMOs did not have a D.C. office. Other than a couple of companies like Kaiser, most of them didn't have a well-established government relations program headed by a senior manager. They do now, but at that time, we were one of the first companies with such a program.

Hughes: How were you received in Washington?

Franklin: We were very well received. FHP already had a consulting agreement with a major public affairs firm that represented us in Washington, as well as our Washington, D.C. office. In fact, I had worked with some of those people in my previous life as a consultant to FHP. One of my jobs was to manage the D.C. office. One of the problems we faced was that our Washington staff had multiple responsibilities, in addition to their D.C. function. As a result, FHP was not getting the maximum mileage out of the operation. We needed to maximize the effectiveness of our people there and that is what we began to do. We clearly developed a major Washington presence, probably the most effective presence of any company in our industry at that time.

Hughes: That was really all you were doing? You weren't involved in any other quasi-legal affairs for FHP?

Franklin: No, I was purely government relations.

Acquisition of TakeCare, June 1994

Hughes: Well, now, is there a story to be told about the period between 1990, when you came on board, and three years later when the talk began about an acquisition?

Franklin: When I came with the company in '90, we were doing about $600 million a year in revenue. By the time of the acquisition in June, 1994, we were at about $2.5 billion. As you can see, there was a huge amount of growth and activity with the company.

Creation of a Public Affairs Function

Franklin: A couple things that were important prior to the merger convinced senior management that we needed to take one step beyond government relations and create a public affairs function, which I also headed up. Public affairs then became integrated into government relations, public relations, community relations, and even some regulatory pieces. We put them all together in one department.

Our CEO, Bill Price, and Dr. Gumbiner allowed us to do that and, as a result, we became even more effective than we already were. This helped FHP deal with the growing media and legislative and official regulatory interest in our industry. We were also able to coordinate our messages a lot better.

About two years ago, as we moved towards the acquisition of TakeCare, we found that TakeCare had nothing like what we had. Unlike other functions, when you matched us up in my area, there was a big difference because they really did not have a government relations function, nor did they have a public affairs function. There simply was no matching department. Their public relations people were purely marketing people. So our function was brand-new to their management. I do believe that we assisted in bringing the two companies together by helping to facilitate the approval and regulatory processes. We could do that because we had developed the acumen and credibility with the regulators.

Reasons for the Acquisition

Hughes: So at that point, the acquisition of TakeCare seemed a good thing to you?

Franklin: Yes. You've got to remember, in '94, we were facing health care reform and legislation in Washington, as well as proposed legislation in the different states, much of it detrimental to our interests. It became very clear that only the larger companies would survive all this, because they could absorb the impact of any negative consequences, as well as take advantage of the opportunities that would arise.

Hughes: What did TakeCare specifically offer? Why TakeCare rather than another HMO?

Franklin: I think we chose TakeCare from a couple of different standpoints. First, there was an excellent geographical match-up. We did not have a huge overlap of territory. For example, FHP had a small operation of a few thousand members in northern California, while TakeCare was very large in northern California. We had a small operation in Colorado of approximately 5,000 members; they were the largest plan in Colorado with more than 300,000 members. TakeCare had a few people in southern California, but we were huge in southern California. From a geographical standpoint, it presented some outstanding opportunities.

Secondly, both in Colorado and in northern California, TakeCare was not into the Medicare business as yet. We were one of the two largest HMOs in the country and were leaders in terms of the Medicare risk product, and the acquisition gave us the opportunity to go into two new locations and grow our successful Medicare product.

Also, in California it gave us flexibility in dealing with the regulatory scheme of things and in taking advantage of the 50-50 rule, which is a federal rule that requires an HMO to have no more Medicare risk members in a given state than it has commercial members. In some states--such as Arizona--this rule makes HMO growth slower and more cumbersome.

Merging Corporate Cultures

Hughes: Did anybody think about the match or mismatch between the two corporate cultures?

Franklin: There was a lot of discussion about the two different cultures. One of the risks that you always run into in these things is whether the cultures will match up. Can they come together? I know there were a lot of discussions at the senior level of the company as to whether the cultures would match up, and how we would help to assimilate TakeCare and bring our organizations together. That's generally one of the hardest things to do in any kind of acquisition or merger situation.

And it's not a short-term thing; it's a long-term process. It takes you two or three years to mesh organizations from a cultural standpoint. You can do it legally and you can do it in the regulatory sense. But it's not until you get the cultures in sync that the organizations really coalesce.

Hughes: How did you initially perceive the corporate culture of TakeCare?

Franklin: Our styles of management were totally different. Their senior management style was laissez-faire. In other words, the view of the president of TakeCare toward the people who ran his operations, whether it was right there in northern California where he was located or in Colorado, was to keep track of the key numbers and leave them to their own devices to perform.

Whereas I think FHP's style was just the opposite. We had a corporate structure that was very much was involved in the lives of our different regions. By 1994 we were in seven different states, plus Guam. We were much more of a hands-on operation.

One of the early clashes of the two cultures was over management style. In TakeCare the regions had a lot of autonomy, and in FHP that autonomy was somewhat restricted by a more tightly operated corporate environment.

Staff and IPA Models

Hughes: FHP was a staff model-IPA [Independent Practice Association] mix. How did that mesh with whatever TakeCare had been using?

Franklin: TakeCare was purely an IPA in all of their regions, so their southern California operation was just added on to FHP's structure down here. There was no problem in terms of staff model versus IPA from that standpoint.

Hughes: And nobody saw any threat to the staff model?

Franklin: The staff model was still a major component of our organizational structure. It was 30 to 40 percent of our business and the IPA was 60 percent of our business. Then, after the acquisition, it decreased to more like a 20-80 ratio. So purely by adding TakeCare's numbers, we became a much larger IPA player. In contrast, the membership in the staff model piece was a lot smaller.

Hughes: Yes, the staff model wasn't directly affected by the acquisition.

Franklin: The changes in the staff model didn't really have anything to do with the increasing size of the IPA or even the acquisition itself.

Hughes: No? Well, what was the problem with the staff model?

Franklin: The discussions over the staff model were management discussions. I'm not necessarily the person to talk to about that because I wasn't privy to most of them. There was a split within the board, even among some senior management, as to the viability of the staff model, how it ought to be organized, and what things needed to be done to make it successful.

Hughes: Well, why don't you describe your role in the acquisition of TakeCare?

Franklin: The first year of the acquisition, or at least the transition into the acquisition, was pretty much normal in terms of what we'd done before. Again, I had the regulatory component; I was responsible for Sacramento and for Washington, D.C. We had full-time offices both in Sacramento and Washington. And then I was in charge of public relations and community relations, along with the government relations function.

Restructuring FHP, June 1995

Creation of Three Divisions

Franklin: A year ago June, there was a decision to re-engineer the corporation and, as a result, we had to make some major changes. But that was a product of the re-engineering and reorganization of the company because of the acquisition and other changes. In addition, there were changes in how we treated the staff-model piece and the IPA piece.

Effect on Public Affairs

Franklin: The corporate role became different because we created the three divisions: the insurance division, the physician practice management group division, and the HMO division. In each of those divisions, then, we centralized some of the resources that particularly applied to each one. As a result, we took the regulatory piece that had been reporting to me, which was mainly HCFA [Health Care Financing Administration] and the federal piece, and we moved it into the HMO division, where I felt it properly should go.

Hughes: Was that your recommendation?

Franklin: Yes, I did recommend that, because Judd Jessup, president of the HMO division, had problems with his individual states in making sure that the regulatory piece fit properly. Part of the goal was to downsize the corporate structure and to make it a lean and mean operation.

Hughes: Which reflects what's going on in the health care field in general.

Franklin: Yes, exactly. So that's the biggest piece that I moved to the HMO division.

We moved the Sacramento office into the California region, which we had been talking about for a year or two anyway. We did that so the Sacramento office would be reporting to the CEO of California. Previously, that had not been the case because we had divided the state into several different regions so it didn't have one overall CEO. Once we had one person in charge of all of California, the Sacramento office was moved under him.

Initially, the Washington, D.C. office stayed in place, and I retained the government relations and public relations here at FHP corporate headquarters. Now, in the process, we also downsized staff. What had previously been a thirty-person staff became a twenty-one-person staff and ten of those people were moved into other areas. So at corporate, at least for a short time, we became eleven. Then the decision came to close the Washington, D.C. office and five people were let go there. When we closed that office, we began to deal even more closely with our D.C. consultant.

Hughes: How did you feel about closure of that Washington office?

Franklin: I think that was the toughest decision we made. It was a very expensive operation to maintain. Obviously, I felt very strongly that we ought to keep it, but with the many cost-cutting measures that we were taking, it simply became one of the casualties. At least we were able to get the resources to upgrade our agreement with our public affairs consultant there, and so that's been working well.

Hughes: Now, these changes came after what Dr. Gumbiner calls "the takeover"?

Franklin: They came after he had left the board in June, 1995.

Hughes: He calls it a back-door takeover. Would you go along with that?

Franklin: I can't comment on those things, because I was not privy to everything that went on there with the board of directors. I still don't know everything that went on. I always reported to our CEO, Bill Price, and had direct access to him as I do to this day. While Dr. Gumbiner was here, I had a lot of support from him and worked with him a great deal.

Mr. Anderson has not had much interest in the public affairs area. He's a different style person in terms of his involvement. Bill Price has been very supportive of my function, and personally involved in promoting the entire public affairs program. And that has never changed.

Hughes: You felt all along that you not only had input, but it was being received?

Franklin: Certainly in my function, yes. I think what happened at the board level is a whole different story, and one that I'm not qualified to comment on.

Corporate Morale

Hughes: What was and is your perception of the effects on morale of the restructuring of the corporation that began in June 1995?

Franklin: Obviously, I think you go through a lot of different stages when you merge two large organizations. Early on there was an excitement about the fact that you've got two organizations that have formed one of the largest companies in our industry in the country. That stage is generally followed by some apprehension. People begin to realize that there will be some jobs lost because of the efficiencies that you have to achieve. Then they become concerned about their own job and the jobs of their colleagues.

A year ago last June [1995], with the re-engineering of the company, it became clear that we were going to have to downsize pieces of the organization. We realized that there would be a number of employees leaving at all levels, not just at middle management or entry-level positions. We knew that a lot of senior managers would be affected. In any organization, that has the natural effect of reducing morale, and a company just has to work through that. They've got to deal with the morale issue as they go along, and it's a hard one to move through.

I'm talking about that because one of the areas in my department is employee communications, and so we were dealing with this issue day-to-day. The questions were: are you through with major layoffs? Has the final piece dropped on this? Are there any more people that are going to leave? You always have to deal with that as candidly as possible and you must communicate regularly with your employees.

And it takes you a few years to rebuild morale. Once you've finished your downsizing, you have a very difficult job of rebuilding the positive spirit of a company. And it takes a few years to do achieve that. In this, we are no different than McDonnell-Douglas or Xerox or any other company.

Hughes: Where is FHP in that process now?

Franklin: I think we're pretty much at the tail end. We've sold two hospitals, so obviously, a number of employees left. The Physician Practice Management Corporation, which is now called the Talbert Medical Group, has pulled out its people. Probably Talbert will spin off from FHP in the next six to nine months, but I think the employees there recognize that and accept it.

So when you're talking about the HMO piece, there's a feeling that we've come to the end of the layoffs and the changes. There are still a few layoffs scheduled, but people know that they're coming. Although employees may not know who specifically will be laid off, they know it's going to happen.

This summer is key for us, because in September we move into our new corporate headquarters where, finally, all the corporate staff will be in the same location. We will start the process of rebuilding spirit and morale and all the positive things that come with the company.

Hughes: So it's been a rough year.

Franklin: Oh, yes, it's been a rough year and a half. But our experience is no different from what the rest of the corporate world is going through. When boards and leadership change, you're always going to have major repercussions throughout the organization.

Change in Management Style

Hughes: What about the fact that the new chairman of the board, Jack Anderson, is a more distanced manager than you are used to having? For much of FHP's history, management has been hands-on, with Gumbiner walking around and making sure that the premises were the way he wanted them, and dealing with people on a daily basis.

Franklin: My experience with Dr. Gumbiner is a little bit different, because a month after I came on board, Dr. Gumbiner retired as CEO of the company and became chairman. Then Bill Price became president and CEO.

Hughes: So you didn't have that experience.

Franklin: Some of the management that Dr. Gumbiner put in place changed over. Even though he remained active, the hands-on leadership was with Bill Price and the board more than at the level right below Bill. There was a management committee that Bill dealt with a lot more than he did with other senior managers.

Now, having said all that, Dr. Gumbiner remained very much interested in and a part of what we were doing in the government relations area, especially as it applied to Washington. He had developed some relationships over the years that both Bill and I utilized, as well as the relationships he had nurtured and the

political skills he had developed. I still worked very closely with Dr. Gumbiner on a lot of the government relations issues.

Talbert Medical Group

Hughes: What is the relationship of the Talbert Medical Group to FHP?

Franklin: In our most recent table of organization, the Talbert Medical Group reports directly to the board of directors.

Hughes: What is the rationale?

Franklin: Again, it comes down to management's and the board's view of what the world of health care will look like in the next few years, and how managed care and managed-care entities are evolving in the scheme of things. I think the judgment has been made at the board level that the best thing for the company is to spin off the medical group and make it a separate entity. The FHP shareholders will still own a large piece of it, but then Talbert will be able to take on new kinds of business, such as other HMOs, PPOs [preferred provider organizations], fee-for-service and the like.

Hughes: The Talbert Medical Group will be the medical arm of FHP under a contract arrangement?

Franklin: One of FHP's major providers will be the Talbert Medical Group, but we have literally thousands of providers. Talbert will be our largest single provider, because in the deal, there is a long-term contract between FHP and Talbert. So Talbert will continue to service FHP patients, but it will also be able to take patients from other entities, some of which may be competing HMOs.

Hughes: But there is no longer an FHP-employed physician, a staff physician, at FHP?

Franklin: We no longer have staff-model physicians. They are in Talbert. The hospitals are sold, the skilled nursing facilities are no longer around, and the medical centers are part of the Talbert Medical Group. So what you have in terms of the staff model is all focused in Talbert.

Hughes: I see.

Franklin: What's happening around the country is that these physician management groups are growing like crazy. In fact, you have a number of them now listed on the stock exchange and a number that are growing quite big on their own. Also there are moves afoot in Washington and elsewhere to allow these groups access to parts of the market to which they traditionally haven't had access. In the Medicare area, there is a discussion of creating what is called Medicare choice, where a Medicare beneficiary would have a choice among staying in a traditional Medicare setting or going with an HMO, PPO, or a physician-sponsored network of some sort.

Marketplace Incentives for Consolidation

Hughes: Was the acquisition and restructuring a general response to what was happening in the health care field in general, or were there some really specific factors that pushed FHP in the direction it took?

Franklin: I was not part of the high-level decisions that drove the actual acquisition itself, but I believe the atmosphere in the marketplace at that time was driving entities to make a choice: either combine into larger organizations or be bought out yourself. If FHP had stayed the size we were, we were very vulnerable to takeover from the outside.

Also, those who were the players in the industry, the companies like FHP and U.S. Healthcare and Humana needed to get to a larger size--

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Franklin: --in order to do business with the major statewide corporations in California. We had to have both a northern California and a southern California presence. Basically we didn't have much of a northern California presence. So I think one of our strategies in acquiring TakeCare was that it gave us a large northern California presence so we are now a major California player.

Secondly, there were other markets out there that we wanted to get into. Colorado clearly was a place we wanted to be. Our choice was to continue piddling along at 5,000 members or to make a major play there. In this instance, we were able to go from being a 5,000 person plan to one with more than 300,000 members, and become the largest HMO in the state. Those were

specific things that were attractive in terms of the acquisition.

But the general market was also driving it. There will be major changes in health care over the next few years, both from a regulatory standpoint and a legal standpoint. The larger companies, either fortunately or unfortunately, are the ones that are going to do well, if they have the right kind of health care delivery strategy. The companies that are going to be hurt are the smaller companies under, let's say, 400,000 to 500,000 members.

Hughes: What do you predict will happen to medical services when developments that are mainly spurred by business or financial pressures?

Franklin: Well, I think that's part of it, but the other part is for you to be competitive in the marketplace. You have to offer new products and services. You have to bring the latest information systems on line. You've got to do a lot of things that are capital-intensive, and the larger you are, the easier it is to bear those costs. In fact, if you're an investor-owned company, you're able to raise that money in the marketplace and generate the capital to do the kinds of things you must do to compete in an extremely tough environment.

As you grow the company, you have to realize that the medical component is primarily a local thing. Tip O'Neill said, "All politics is local." That's true in health care as well. In other words, people still look to their local medical center for their care, and they don't really care whether you're 100,000 members, 1 million members, or 10 million members.

Satisfying Patients

Hughes: Isn't the bottom line that a company has to please its patients?

Franklin: Absolutely. In fact, we're dealing in an atmosphere where cost --cost to the member and to employers--is becoming much the same for every company. Cost is not going to be the issue in the future. The issue is going to be service. Those organizations that provide the best service to their patients are the ones which are going to survive. The survivors will include those companies which have accommodated themselves to the changing marketplace and developed new product lines, including point-of-service and direct-access products. I question whether smaller plans are going to be able to do that.

Debating Organizational Structure

Hughes: Well, we've talked rather abstractly about market forces, et cetera. Do you have any comment at the level of the individual? Put succinctly, do you see personality playing a role in the takeover and restructuring? Was that a matter of external forces, or was there a role for the individual personality, the individual vision of how things should be?

Franklin: In terms of the structure, I know it was not something created over one weekend. And I don't think it was done as a result of the TakeCare-FHP merger. Some of the discussions about how we should be organized were going on as much as two years before the acquisition.

I'm generally aware that there was a debate going on as to what we should do with the staff-model operations, how to expand the IPA operations, and what our mix of membership ought to be. The eventual decisions about how we would be organized did not occur in a vacuum.

Clearly, there were significant disagreements on what should be done, one side represented by Dr. Gumbiner, and the other side by Jack Anderson and other members of the board. Which one was right, history will prove one way or another, but the staff model was certainly one of the major issues that split the board from time to time.

Hughes: I realize you're speaking as an outsider to the board deliberations, but what is your view of what those two positions were?

Franklin: On the one side, there were people who believed that the staff model should still be integrated into the company and its profitability viewed in a different light than just looking at it as a stand-alone profit center. On the other hand, there was the view that in the rapidly changing world of health care, the high operational cost of the staff model, and the capital requirements to keep it up to date, pointed toward separating it from FHP and making it its own entity. In my view, those were the two theories.

Right now, the latter theory is winning out not only in FHP, as represented by the change over the last year or two, but also in many other companies that are beginning to move in the same direction. Even Kaiser, which has been a staff-model giant over the years, is creating some IPAs and making arrangements with companies to create point of service products.

It's a fascinating process to watch because the changes in health care are driven by what happens in the marketplace. Yet I don't think they are being driven so much by Wall Street, even though there is considerable pressure on any publicly held company to produce quarter by quarter. Instead, the changes are being influenced by where people perceive the marketplace is heading over the next two to five years.

Views on Future Managed Care

Managed Care as a Process

Franklin: Let me give you a little philosophical speech. I believe that managed care is where health care is heading in this country. What we're going through right now, especially in the anti-managed care legislative and media environment, is a result of this fundamental change in our health care system.

Now, when I say managed care, I'm not talking about just an HMO or a PPO or a physician practice management group. I'm talking about a process, because I happen to believe that managed care is a process. And when a process causes a major portion of your economy to change--and this is a trillion-dollar piece of our economy that's changing--then you're going to have winners and losers. And the winners right now are those who are involved in managed care, like HMOs and PPOs and others. And when things change, naturally they will affect some people in a negative way. Then the losers go to the government and to the media for protection. So I think that's what you're seeing in the current anti-managed care environment.

I believe what you see today is not what's going to be here five or ten years from now. The companies that survive over the next decade are those that make the changes necessary to remain competitive. Again, what we see today may not be what we see tomorrow. We very well could end up back at some huge staff-model operation again. But I don't know that. At least for now, people certainly seem to support what we're doing.

Hughes: It's an evolutionary process that you're describing.

Franklin: Yes. FHP is not the same company it was five years ago, ten years ago, fifteen years ago. And the marketplace, especially in the last five or six years, continues to evolve. And it's changing throughout the country, not just in the west. The

creation of these physician practice management groups means a whole new ball game that is really only three years old. You look at the recent acquisitions and mergers made by Mulliken and Caremark. You're talking about billion-dollar enterprises with thousands of doctors who are part of the company. And they're now publicly held. That's a different dynamic from that of the local doctor who hung out his shingle and started seeing patients.

Hughes: As far as I know, FHP is the only health care organization that has evolved through virtually all the forms of medical service delivery this country provides, starting with a private-practice, fee-for-service model. That evolution makes FHP a wonderful model for studying the forces that induce these changes.

Medicare

Franklin: In the next few years, I believe you're going to see major changes. The last big change in Medicare was in 1973 when they passed the HMO Act, and a number of things evolved from that, including--in the early eighties--the Medicare risk program.

But the Medicare risk program has not really been that large, even though at FHP it has grown significantly. But compared to the total number of Medicare recipients, the number in Medicare risk programs is still relatively small. But that will change. And I believe it is going to start changing next year and will be driven by the need to stabilize the financial solvency of the Medicare trust fund. I think you're going to see a whole new setup where people in Medicare will no longer have fee-for-service arrangements where the government opens up the coffers and lets everybody go see whichever doctor they want. And then the government coughs up the dollars to pay the doctors and other providers. I think you're going to see Medicare evolve to where seniors have the same choices in the marketplace that the commercial sector has. In other words, they can stay in Medicare or they can go to other kinds of entities.

From a legislative standpoint, what we look for is to make sure that whatever change happens there is a level playing field created for everyone. If physician groups, PPOs and others have access to Medicare risk contracts, it must be structured evenly so that HMOs can still compete equally in that environment. If

an unlevel playing field is created, then others are going to have big advantages, and we need to avoid that situation.

Hughes: Well, fascinating. Is there anything more you want to say?

Franklin: No, that's probably my diatribe for today.

Hughes: [laughs] Well, thank you.

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AN INTERVIEW WITH BURKE GUMBINER

Interview Conducted by
Sally Smith Hughes
in 1996

Burke Gumbiner.

Regional Oral History Office
Room 486 The Bancroft Library

University of California
Berkeley, California 94720

BIOGRAPHICAL INFORMATION

FULL NAME: Burke Franklin Gumbiner

DATE OF BIRTH: 10/25/50 **BIRTHPLACE:** Long Beach, California

FATHER'S FULL NAME: Louis Robert Gumbiner

OCCUPATION: Retired **BIRTHPLACE:** St. Louis, Missouri

MOTHER'S FULL NAME: Josephine Schlenck Gumbiner

OCCUPATION: Retired **BIRTHPLACE:** Oxford, Ohio

YOUR SPOUSE: Kera

OCCUPATION: Interior Designer **BIRTHPLACE:** Philippines

YOUR CHILDREN: David, Tali Ruth, Shiri

WHERE DID YOU GROW UP? Long Beach, California

PRESENT COMMUNITY: Corona Del Mar, California

EDUCATION: 1972 BA Political Science @ UC Santa Barbara (California); 1977 MBA @ CSULB (California)

OCCUPATION: Senior Vice President of FHP International; President - Insurance Group

AREAS OF EXPERTISE: HMO, Medicare, Marketing, Advertising, Insurance, Workers' Compensation

OTHER INTERESTS OR ACTIVITIES: skiing, scuba diving, surfing, children

ORGANIZATIONS IN WHICH YOU ARE ACTIVE: Mirman School for Gifted Children

BURKE GUMBINER

Mr. Gumbiner is President of FHP International's Insurance Division. He is also a Director and Senior Vice President of FHP International Corporation, a Director and Senior Vice President of FHP, Inc.; Director & Executive Vice President of FHP Financial Corporation; Director & Senior Vice President of FHP, Inc. and TakeCare, Inc.; Director, Chairman, and President of FHP Life Insurance Company, and Director, Chairman & Senior Vice President of Great States Insurance Company, and Great States Administrators, Inc.

Mr. Gumbiner graduated with a BA in Political Science from the University of California at Santa Barbara in 1972. He received his MBA in 1977 from California State University at Long Beach.

Mr. Gumbiner has held a variety of positions in the HMO business starting as a Sales Supervisor for FHP in 1972. In 1975 he became Marketing Manager for FHP in Utah and in 1977 became Marketing Manager for Roosevelt Health Plan in Illinois. Health Maintenance Life Insurance Company hired him as their Vice President of Marketing in 1978 and he became Executive Vice President of HML, a wholly owned subsidiary of FHP, Inc. in 1980. In 1981 Mr. Gumbiner became Vice President of Marketing for FHP, Inc., and in 1986 was promoted to Senior Vice President. Mr. Gumbiner became Senior Vice President and Chief Operating Officer of the Insurance Division in 1994 and then its President in 1995. Mr. Gumbiner's responsibilities include FHP's Insurance Group, and Preferred Plan (FHP's National PPO).

BIOGRAPHICAL AFFIDAVIT OF
BURKE FRANKLIN GUMBINER

ATTACHMENT TO ITEM No. 10

DATE	EMPLOYER	POSITION
1994-Pres.	FHP International Corporation, Fountain Valley, CA	Sr. Vice President and President of the Insurance Division
1986-1993	FHP Inc. Fountain Valley, CA	Senior Vice President
1981-1986	FHP Inc., Fountain Valley, CA	Vice President, Mktg.
1980-1981	*Health Maintenance Life Ins. Co., Fountain Valley, CA	Executive Vice President
1978-1980	*Health Maintenance Life Ins. Co., Fountain Valley, CA	V.P., Marketing
1977-1978	Rockridge Health Plan, Oakland, CA.	Marketing Manager
1976-1976	FHP of Utah, Inc.	Marketing Manager
1975-1975	FHP Inc., California	Group Sales Representative
1974-1974	FHP Inc., Guam	Group Sales Representative

* A subsidiary of FHP Inc., Name changed to FHP LIFE Insurance Co. 4/24/87

CURRENT DIRECTORATES AND OFFICERSHIPS

Director, Chairman and Senior Vice President, FHP Life Insurance Company
Director, Chairman and Senior Vice President, Great States Administrators, Inc.
Director, Chairman and Senior Vice President, Great States Insurance Company
Director, Chairman and Senior Vice President, Ultralink, Inc.
Director, Chairman and Senior Vice President, FHP Reinsurance Limited
Director, Chairman and Senior Vice President, TakeCare Insurance Company
Director, Chairman and Senior Vice President, TakeCare Life Insurance Company
Director and Senior Vice President, FHP International Corporation
Director and Senior Vice President, FHP Inc.
Director and Senior Vice President, FHP Financial Corporation
Director and Senior Vice President, TakeCare Administrative Services Corporation
Director and Senior Vice President, TakeCare, Inc.
Director, Hippodrome Galleries Corporation
Senior Vice President, Peak Health Plan of Idaho, Inc.
Senior Vice President, FHP International Consulting Group, Inc.
Vice President, Health Maintenance Life, Inc.

V AN INTERVIEW WITH BURKE GUMBINER

President and Chairman, FHP Insurance Division

[Date of Interview: July 8, 1996] ##[1]

Hughes: Have you had a promotion since we last talked, because you're now president and chairman of FHP Insurance Division?[2]

Burke G.: Well, I wouldn't say I've had a promotion. I've always been president of the insurance division. But I have assumed additional responsibilities in that I'm president and chairman of the different insurance companies. My position has essentially remained the same, which is president of the FHP Insurance Division.

Hughes: What exactly does the insurance division comprise?

Burke G.: It comprises the insurance companies and the PPO [preferred provider organization] that FHP owns, that insure individuals for either life insurance, worker's compensation, PPO, or other types of health insurance.

Acquisition of TakeCare, June 17, 1994

Consolidation in the Health Care Industry

Hughes: The next thing to talk about is the acquisition.

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[1]## This symbol indicates that a tape or tape segment has begun or ended. A guide to the tapes follows the transcript.

[2] Burke Gumbiner was interviewed in February 1992 for the oral history with his father: Robert Gumbiner, M.D., "FHP: The Evolution of a Managed Care Health Maintenance Organization, 1955-1992," Regional Oral History Office, University of California, Berkeley, 1994.

Burke G.: Which acquisition?

Hughes: Of TakeCare.

Burke G.: Oh, okay.

Hughes: Is there something else that I should know about?

Burke G.: Well, we had acquisitions in the insurance division.

Hughes: In about 1993, I understand that FHP began looking for an acquisition. Do you know why that was?

Burke G.: Yes, because FHP was then in a position where we were becoming rapidly one of the smaller HMOs as the industry consolidated. The HMO industry has been in a process of consolidation, and although we were large, we were steadily becoming [relatively] smaller as bigger HMOs bought smaller ones, and it's still continuing today. We felt that in order to remain independent, we either had to acquire someone or we would probably end up being acquired. So the board felt that we should remain independent and try to be acquirer instead of acquiree.

Hughes: [laughs] A much better position to be in. How did the acquisition relate to your program in northern California?

FHP Programs in Colorado and California

Burke G.: One of the opportunities with the TakeCare acquisition was that we felt we would gain commercial enrollment in both Colorado and northern California, and then be able to market our senior plan. So an extra benefit of the acquisition was to gain senior enrollment in those two markets.

Hughes: Why TakeCare?

Burke G.: Well, we looked at various acquisitions, but TakeCare had a large enrollment base in northern California and in Colorado. Those were their two main areas. In California, it allowed us to consolidate our position, doubling the size of the company in California, and then also to become the number-one HMO in Colorado. And it gave us a foothold in the Midwest, which we're now expanding. TakeCare was an HMO that fit in with our locations and also was available.

Hughes: Your father maintains in retrospect that the TakeCare organization was not properly evaluated by FHP.[1] What would you say about that?

Burke G.: Oh, I think it was properly evaluated. I don't know exactly what he's referring to. Is there anything specific you could give me on that?

Hughes: I think he was talking about the structure of TakeCare, which he described as comprised of three loosely connected entities, which he said were "dressed up for sale".[2]

Burke G.: Well, I don't know what he means by that. I think that TakeCare was run on a decentralized basis, that's for sure, and you have to look at each of the entities separately. It was four separate entities, to be exact. It was Colorado, Illinois, Ohio, and California. The biggest problem that FHP has had in assimilating the TakeCare acquisition is assimilating the California piece, trying to combine our HMO with TakeCare's in California. FHP has had its own problems in California.

One of the biggest problems that FHP has had is the continued loss of membership in the staff model, which we've now spun off into a separate corporation, and the fact that we were continuing to lose membership in our company-owned hospitals, which we've now sold. So I think that FHP had its problems in California, and TakeCare also had problems in California. They were predominantly located in the north, where they did not have the most competitive provider contracts.

So I think you've got two companies, both of which had some problems in California, that by combining gave us enough volume in California so that we could rectify some of these problems. We're looking forward to having California be in pretty good shape going forward, especially next fiscal year and onward. But we've had to live through some problems in California that both companies had.

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[1] See the oral history in this volume with Robert Gumbiner.

[2] Robert Gumbiner. "Chronology of Back-door Takeover of FHP Int. by TakeCare (Purchased by FHP)," August 4, 1995. (Unpublished document courtesy of Robert Gumbiner.) Hereafter, "Chronology of Back-door Takeover."

Now, you can't say that at all about Colorado. Colorado was always run extremely well and made money and has been a good region. So Colorado never has been a problem and continues to be a good region and was one of the big pluses of acquiring TakeCare. Illinois and Ohio are smaller regions that are profitable but are mainly startup regions that we're going to grow. They're not big regions; they're both about 50,000 members, but they have the potential to be bigger in the future.

The two major two areas you had to look at with TakeCare are the northern California and Colorado regions, which were the two big ones.

Hughes: Would you say those were the two main reasons for acquiring TakeCare?

Burke G.: Right. I don't think we acquired TakeCare for the Illinois or Ohio regions, because they're small. It gave us a head start in getting into those areas. In California, [the acquisition] allowed us to go from 400,000 to 800,000 members, and then be big enough in California so we could be a player. Otherwise, we'd just be slowly squeezed out. We bought the biggest HMO in Colorado, and [FHP] only had a startup there, and so now we're the largest HMO in Colorado. In Illinois and Ohio, we gained two startup regions that we're now trying to build into something.

Hughes: The staff model was never operative in any of those regions? Except for southern California, of course.

Burke G.: No, the staff model was never operable in any of the TakeCare regions.

Hughes: Except southern California.

Burke G.: In southern California, but TakeCare was never very big in southern California. You were basically buying northern California, Colorado, and Illinois and Ohio. TakeCare had membership in southern California, but the bulk of their membership was in northern California, whereas the bulk of FHP's membership was in southern California. So therefore, by making the acquisition, you end up with an HMO that's located in both northern and southern California.

Effects on Top Management

Hughes: Acquisition obviously was a board decision. Did employees in general consider acquisition of TakeCare a good idea?

Burke G.: Well, at the time, the employees felt that it was great. They said, "We're doing the acquiring." Everybody likes to work for a company that's acquiring another company, because they think, We're going to be on top.

Hughes: Right. [laughs]

Burke G.: FHP had never been through an acquisition of that size, and afterwards it was truly a situation where some of the TakeCare people ended up on top, and some FHP people ended up on top. It wasn't just 100 percent FHP people on top. So if you were one of the FHP people that didn't end up on top, you were obviously disgruntled, because you went into the thing thinking, We're acquiring them; I'm going to be on top, and hey, how come the TakeCare person is on top now?

Hughes: The general feeling was that FHP in all regards would be on top?

Burke G.: Right.

Hughes: Was that realistic? Does the organization that takes over usually end up on top in all regards?

Burke G.: Well, it depends on how it's organized. If they go into it with a theory that high-ranking TakeCare individuals will manage the operation that they've just taken over, then they won't necessarily end up on top. But if you design it, we are going to go in and fire everybody from TakeCare and insure that it's strictly FHP on top, then FHP would 100 percent of the time be on top.

Well, we didn't design it that way. We gave the top TakeCare management three-year contracts. Obviously, we weren't intending to go in there and fire them all.

Hughes: Was it clear in the negotiation process that TakeCare would be moving into some of the senior positions?

Burke G.: Yes.

Hughes: It was always clear from the start?

Burke G.: Yes, from the beginning. That's why they were given contracts.

The Board of Directors

Expanding Membership

Hughes: When did you become a member of the board of directors?

Burke G.: Oh, I've always been a member; I've been a member since the company first became a private for-profit company. I had been on the board of the nonprofit [company] off and on, but then I became a board member of the for-profit company, which is now FHP International, when it was founded in 1984. I was one of the original shareholders. That's the company that owns FHP. That's the publicly traded company.

Hughes: Could you describe the tenor of board meeting during this period of acquisition and then takeover?

Burke G.: Like I said, they saw FHP as becoming a smaller player relative to others as the industry consolidated, and saw the acquisition as a means of making FHP a major player.

Hughes: Board membership was changed in June of 1994. It had been eight up until then? Was that in the rules and regulations?

Burke G.: This gets back to the fact that we were trying to include TakeCare as part of the management team--we guaranteed them two board seats.

Hughes: The rules were changed so that board membership would be no less than seven and no more than eleven. So had it been a maximum of nine members before?

Burke G.: I think it was lower than that for a period of time, because we had some board members that resigned, but then they changed it to make it at least nine. I don't remember exactly when that happened, but that happened near the time of the acquisition, and it allowed us to have enough seats so we could add the two TakeCare members.

Hughes: The expansion of the board occurred on June 24, 1994.[1]

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[1] "FHP Chronology" courtesy of Robert Gumbiner's office.

Burke G.: We made the TakeCare acquisition in July of '94, right?

Hughes: The TakeCare acquisition closed on June 17, 1994.[1]

Burke G.: Well, the board was expanded right at the time the deal closed, because part of the deal was we had to add two TakeCare people onto our board, and we needed to have a big enough board to be able to do it.

Hughes: Those two people were Jack Anderson, and who was the second?

Burke G.: [Richard] Burdge.

Hughes: Was there anything immediately apparent about how things might be in the future?

Burke G.: The two TakeCare board members were experienced HMO executives, and they came onto the board and they wanted to have a say-so on how things were run. They weren't non-HMO executives that would defer to management who had the HMO experience. These were two seasoned HMO executives.

Hughes: Who was on the board besides you and your father that had that kind of experience?

Burke G.: There was Bill Price.

Richard Rodnick

Hughes: Richard Rodnick resigned from the board on June 30, 1994.[2] Was his resignation somehow related to the acquisition?

Burke G.: No. He was a board member of another company that had some serious problems with derivatives, and he had to devote all his time to that and just didn't have the time to devote to our board. Remember the derivative crisis when all the companies were taking gas?

Hughes: From what I understand, he was the person on the original FHP board who had the most experience with acquisitions and mergers.

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[1] Ibid.

[2] Ibid.

Burke G.: Yes. Well, he advised us and helped us up until he resigned.

Hughes: Would history have turned out differently if Rodnick had stayed on the board? Could he perhaps have guided FHP past some of these obstacles that were soon going to appear in its trajectory?

Burke G.: I think he could have possibly had an influence. He would have been another vote; he would have definitely swayed the vote. I remember having meetings with Rodnick, and he was advising us on the acquisition. He did advise us up until he resigned.

Hughes: He advised you to acquire TakeCare?

Burke G.: Right, definitely. He voted for it up until the time he resigned.

Takeover

February 24, 1995 Board Meeting

Hughes: In February, 1995, Anderson called a special meeting of the board.[1] Do you remember?

Burke G.: Right. To discuss what?

Hughes: Yes, I was wondering if there was a stated purpose.

Burke G.: There was a stated purpose to discuss the fact that we had dual CEOs, I believe. I don't know if that's the meeting.

Hughes: Yes, that is the one.

Burke G.: Anderson felt we should only have one president, period, so he could hold one individual accountable for the performance of the company, and my father disagreed with that. Anderson mustered the votes to outvote him on that and have Mark Hacken removed as co-CEO.

Hughes: Right, and that did in your father's idea of the Office of the President, right?

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[1] Ibid.

Burke G.: Right.

Hughes: What was your opinion of how the office had been working?

Burke G.: I voted against that. I felt that the Office of the President should be maintained.

Hughes: Why?

Burke G.: I didn't feel there was a need to change it.

Hughes: Why did you think it was all right?

Burke G.: Because it has precedents. There are a number of companies that have done that. Also, it provides two individuals with different skills and perspectives. I think they [Price and Hacken] both individually had value. Plus, Mark Hacken's contract was going to be up at the end of that year anyway; there was no need to [remove him] precipitously.

Hughes: If his contract had expired, was your feeling--

Burke G.: Well, I thought that was the appropriate time to decide whether or not we want to extend it. There was no need to break his contract midterm.

Hughes: You thought that the combination of Price and Hacken worked pretty well?

Burke G.: Yes. I felt it had benefit, and that we needed to have Hacken finish out his contract and then do a formal evaluation of it at that time, not to precipitously end it midterm.

Hughes: Now, Anderson must have chosen Price to be CEO, right?

Burke G.: Right.

Hughes: Did he explain to the board what his thinking was?

Burke G.: Yes, he felt that Price was the most qualified of the two individuals, and had the most HMO experience, and had been with the company the longest.

Hughes: Then Hacken filed a suit against FHP for wrongful termination. Do you remember that?

Burke G.: No, I was not aware that he filed a suit, but he did resign from the board eventually, and FHP negotiated a severance package with him.

Hughes: I get this information from a documents that your father wrote.[1] Maybe Hacken threatened to file a suit.

Burke G.: He might have threatened. The board had the ability to terminate Hacken's contract with thirty days' notice. Then the board assigned Joe Prevratil the responsibility of negotiating a severance arrangement with Mr. Hacken if he also desired to resign from the board at that time. They negotiated one, and then it was presented to the board at a later date.

March 9, 1995 Board Meeting

Hughes: On March 9, 1995, there was a board of directors meeting in Utah.[2] Does that ring any bells?

Burke G.: Yes, that was a regular board meeting.

Hughes: I know your father did not attend, because he was ill.

Burke G.: Right.

Hughes: Do you remember what happened at that particular meeting?

Burke G.: Well, nothing out of the ordinary happened. Hacken attended the meeting.

June 15, 1995 Meeting

Hughes: At the June 15, 1995 board meeting, a lot happened. Do you want to describe what you remember?

Burke G.: What happened at that meeting was that there were eight members of the board--Anderson, Burge, Prevratil, [Warner] Heineman, Price, myself, Hacken, and my father. Hacken resigned from the board the day before the meeting, and that reduced the board to seven.

Hughes: Now, what was behind that?

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[1] "Chronology of Back-door Takeover."

[2] "FHP Chronology."

Burke G.: He had negotiated a severance deal with Prevratil, and that was presented to the board for approval in the meeting of the 15th. He had obviously negotiated a severance deal that he felt was adequate, and he wanted to get out. He didn't want to be in the company after he'd been forced out as president. But what that did, in effect, it gave Anderson enough votes to overthrow my father, because he had now four out of seven votes, depending on how Price voted. But if Anderson was unable to get Price's vote, he would have been deadlocked, four to four. He could not have replaced my father as chairman. But without Hacken, he had lined up Prevratil, Heineman, and Burge; he had the three other votes, so he had a bloc of four votes to be able to replace the chairman.

Hughes: So it wasn't coincidence that Hacken resigned just prior to this meeting?

Burke G.: I don't think it was coincidence. I'm not inside Hacken's mind, so I don't know. I mean, I can't read his mind; I never talked to him.

Hughes: Who was negotiating the severance package with Hacken?

Burke G.: Prevratil. My understanding was that Prevratil was assigned that responsibility. I remember that occurring in the previous board meeting when Hacken was replaced or terminated.

Hughes: But Prevratil probably wasn't acting as a free agent, was he?

Burke G.: I assume he consulted with Anderson.

Hughes: Well, that's what I'm trying to get at.

Burke G.: That's my assumption. I wasn't involved in--

Hughes: It obviously was to Anderson's advantage to have Hacken out of there by the time of the board meeting.

Burke G.: Yes. I was not involved in those negotiations, so I can't really say.

Robert Gumbiner's Resignation as Chairman of the Board, June 22, 1995 ##

Hughes: The night before the June 15, 1995 board meeting, Prevratil met with your father and tried to convince him to resign.[1]

Burke G.: Yes. I wasn't there; that's what my father told me. That's what I assume.

Hughes: When did you learn about that?

Burke G.: Well, just from him.

Hughes: Did you know that when you walked into the board meeting the next day?

Burke G.: No. I did not receive any call or anything from my dad prior to that board meeting.

Hughes: Why did Prevratil want your father to resign?

Burke G.: Well, the basic reason why all four members wanted my father to resign, the number-one reason, was a fundamental disagreement in strategy in terms of the direction the company should go. The majority of the board felt strongly that the company should sell the hospitals, spin off the medical group, and not be in the business of directly providing care. They felt that in order to survive, the company had to be an HMO that contracted with groups and IPAs, that was an arranger, an insurer of care, and a partner with different medical groups and contracting with multiple medical groups and IPAs. They felt that it was not financially viable for the company to continue having its own hospitals and trying to provide care directly, and they felt that continuing to be in that business would threaten the financial viability of the company.

And my father was dead set against that. He felt the company should be in the hospital business and should own its own hospitals and medical centers and employ doctors. So they just had a fundamental strategic difference that there was no way they were going to agree on.

Hughes: Which side did you come down on?

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[1] "Chronology of Back-door Takeover."

Burke G.: I thought we should definitely get out of the hospital business, but I thought we could stay in the medical group business and have a mixed model with the IPAs and medical groups. That was a plausible way to go.

Hughes: Which is the way FHP had been going in recent years?

Burke G.: Except that my father's concept of a mixed model included hospital ownership, which I didn't feel was financially viable. But the non-hospital piece I felt was financially viable. However, the alternate proposal, which was to spin off the medical centers into a medical group and have that group contract with multiple payers, including FHP, I also felt that that strategy could work equally as well. I felt that either strategy could work, and I felt that there was no need to replace the chairman.

I felt that a lot of the ideas that my father had were good, such as his belief in strong marketing and strong centralized control at corporate [headquarters] over marketing and medical management. I supported those ideas, and I felt his concept of a mixed model staff model could work, and that we could have pared down the two hospitals and just not build any new ones. So I voted against having him replaced as chairman.

Hughes: Were you the only one?

Burke G.: Yes.

Hughes: So it was the two of you.

Burke G.: Right.

Hughes: Well, then what happened?

Burke G.: Well, that was it. He was replaced, and the company went on and did proceed to sell the hospitals and go forward with the strategy of spinning off the medical centers into a separate medical group, which is what the majority of the board wanted.

June 26, 1995 Board Meeting: Restructuring

Hughes: Well, there was a meeting just a few days later at which your father resigned and the plans for restructuring were discussed.[1] Do you remember that?

Burke G.: Yes.

Hughes: That was the beginning of restructuring?

Burke G.: Right.

Hughes: Is there anything to be said about that meeting?

Burke G.: No. Like I said, it was exactly along the lines that the majority of the board wanted. What they wanted, my father would never agree to. So now with him out of the way, they could proceed with the restructuring that they felt was best for the company.

Reactions

Hughes: How did your father react to all this?

Burke G.: He resigned.

Hughes: I know, but on a more personal level, how did he react?

Burke G.: Well, he feels it's a mistake, and he doesn't agree with it.

Hughes: What about morale? In general, what did you sense at corporate?

Burke G.: Well, part of the restructuring was to downsize corporate tremendously, and my experience has been that if you're in a unit that's being downsized, the morale isn't that good, because it's being downsized. They could lose their jobs. Whereas out in the regions, the individual regions, morale is better. They're saying, "Well, now, we're independent. We don't have corporate breathing down our neck and we can do our own thing. We like this." So I think it depends on what unit.

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[1] "FHP Chronology."

I would say the morale at corporate is worse, but the morale in the regions could be better. It depends on the region.

Talbert Medical Group

Hughes: How has the spinoff of the medical group worked?

Burke G.: Well, it hasn't been spun off yet. It's being prepared to be spun off.

Hughes: But there is a medical group?

Burke G.: Yes, it's been formed as a separate company [Talbert Medical Group], and the losses have been cut substantially. It was substantially reduced.

Hughes: In size?

Burke G.: In size, and the losses have been reduced.

Hughes: What is the point of spinning it off?

Burke G.: Well, because now, in order to grow revenue, it has to contract with different HMOs as payers and have multiple HMOs as payers, and it's a conflict of interest were it to remain a part of FHP. It's difficult to contract with different HMOs when you're owned by a competitor, FHP. So the strategy is to spin it off so it's totally independent, and then it can go out and contract with other HMOs and will be more successful in generating revenue.

Management Styles

Hughes: Would you comment about Jack Anderson and your father in terms of management style?

Burke G.: Oh, definitely totally two different management styles. My father is more of a builder, a marketer, and a revenue-grower, where Anderson is more of a restructurer, cost-cutter, and strict financial controls and expense controls. Anderson believes in reducing expenses to the level of the revenues, whereas my dad believes in growing the revenues to cover the expenses.

Hughes: How does Anderson's direct experience in the HMO field compare to your father's?

Burke G.: Well, he's had a lot of experience. TakeCare was around for a while and it was very successful. He was with INA [Insurance Company of North America] before that. They've both had their experience, but Anderson has had no experience in actually providing care. He's just strictly been in the management side.

Hughes: Do you think that he came to the acquisition with the idea of a takeover?

Burke G.: I don't know; I can't read his mind. He might have.

Hughes: Well, there could have been some signs early on that you now look back on and interpret in that light.

Burke G.: Basically, I think Anderson is the kind of guy that just wants to get his way in terms of how he thinks the company should be run. If he can do that without being chairman, that's fine. But if the chairman's blocking him, then he'll step in to take over. So he basically wants to be able to control the strategy of the company to try to get the stock price up. I think he strictly looks at it as an investor.

Hughes: Your father talks about providing the best health care available for the best price. It sounds, from what you're saying, that Anderson is a bottom-line person, who perhaps doesn't prioritize quality of health care delivery?

Burke G.: Well, I think he wants to provide good quality, but he relies on the medical groups that we contract with to do that. He basically says, "We're going to contract with medical groups; we're not going to be a medical group. And those groups that we contract with have the responsibility for delivering quality of care, and if they don't, we're going to terminate our contract and contract with somebody else."

Hughes: But knowing your father as you do, Anderson's is a more distant way of controlling quality of medical care.

Burke G.: Right.

Hughes: Your father was there on the site making sure at a micro-level that his idea about high-quality health care was being delivered.

Burke G.: Yes. That's the basic philosophical difference, that Anderson did not want to be in the business of providing medical care. He's saying, "Look, we don't provide it. We contract with somebody else to provide it, and that somebody else is responsible for guaranteeing the quality, and we will oversee them, but we are not going to be directly providing medical care. We're not doctors; that's not what we're going to do. We're administrators. We act more like an insurance company, not a hospital or a doctor group."

Quality of Medical Care

Hughes: How is this new philosophy working out in terms of the patient?

Burke G.: In terms of satisfaction surveys, they look fine; they don't look any different. The patients believe they're getting their care now from Talbert Medical Group. They view FHP as the insurance company, and the medical group is the medical group.

Hughes: Patients who used to be members of FHP and are now getting care from Talbert see no difference in the quality of medical care?

Burke G.: Yes, I would say they don't see any difference, because the doctors are going to try to do the best they can. I mean, they could get sued for malpractice. They are not out there trying to skimp on care or anything. Physicians are trying to do the best job they can. If they're working for an HMO, and an HMO is impeding them from giving good care, then they're going to quit, or they'll get fired because they're just going to do what they need to anyway. HMOs these days are under a lot of scrutiny. They can get sued if they give bad care. So I think everybody is striving to give good care.

FHP wants all of its HMOs to have NCQA [National Committee for Quality Assurance] accreditation, and they want to have good marks in terms of customer satisfaction. In fact, one of FHP's marketing strategies is to be one of the best in terms of quality and customer satisfaction. So we're striving to do that, but we're going to do it through delegating it to physician groups as opposed to being the physician group ourselves.

Robert Gumbiner's Chairmanship

Hughes: Do you see your father's illness and surgery figuring in this story?

Burke G.: Yes, I do. I definitely feel that he was not around enough and not able to devote enough time to possibly persuade some of the board members over to his point of view, and also to spend enough time to be able to develop a strategy that he could build a consensus around.

Hughes: Well, this was not just limited to his illness, was it? He had retired and had taken up a new life, so to speak. You could argue that, surgery or not, he was not around as much as he had been before retirement.

Burke G.: Right, that's the other aspect of it: you can't be a retired chairman of a Fortune 500 company. You're either full-time or not chairman. The chairmanship of a Fortune 500 company is a full-time job. He did not want to devote that amount of time; he wanted to be retired but still be chairman. So I think it's a natural evolution when you look at it. He either had to make the decision to be in it full-time or out.

Hughes: Did you sense any unrest on the board that it didn't have a full-time chairman?

Burke G.: Yes. I think that that played a part, because they just didn't feel that he was spending the necessary time. But also he was not spending the time discussing the issues with them so that they could be persuaded that his point of view was right, or could have come up with some compromise that they would have accepted. Meanwhile, Anderson was spending the time and with the board members continuously discussing his point of view and why his strategy was the proper way to go.

Merging Corporate Cultures

Hughes: Was there any deliberate plan to merge the cultures of the two companies?

Burke G.: No. There should have been more attention paid to that, but in retrospect, I don't think enough time was spent to merge the cultures of the two companies.

Hughes: What could have been done that wasn't?

Burke G.: Well, first of all, there had to be consensus at the board level on the strategic direction of the company. And it finally did come about when my father was replaced; then there was a clear direction established in terms of the restructuring and what the company would do.

But I think it's difficult to merge two cultures. I think a new culture is emerging now, but you have to have strong leadership at the top and define exactly what the culture is and then disseminate that through the ranks.

Hughes: How do you disseminate a culture?

Burke G.: You have meetings and talk to people and send out written communication. You hit them with all types of communication.

FHP and the Current Health Care Context

Hughes: What is the relationship between this acquisition and takeover and the current health care scene?

Burke G.: It's a continued consolidation within the HMO industry, and it's ongoing. So we're just part of it.

Hughes: Is there also an element of the medical profession having less of a voice? Jack Anderson is an example. As you said, he doesn't want to be involved with the medical aspects.

Burke G.: Well, yes, I think that's what's happening, but what now also is happening is that the doctors are forming medical groups. Those medical groups are where they can have influence over management. Whereas prior to that, there was more influence in the HMO itself. But the HMOs themselves were the beginning of the medical industry, which is an unmanaged cottage industry becoming like a [managed business]. Individual doctors cannot operate as a little stand-alone business, because the medical business is consolidating, and there are more efficiencies and economies of scale with a larger enterprise. I mean, there are more tests available; they've got more access to research, more access to technology, and on and on. The idea of the family doctor operating in his little office is not where it's at today.

Hughes: That's for sure.

Burke G.: What you're talking about is large medical groups--that's what it's evolved to. And these groups are not HMOs. The only HMO left out there that has its own hospitals and physician offices is Kaiser, and it's the Kaiser Permanente Medical Group. It's a group that [Kaiser Health Plan and Hospitals] contracts with exclusively. But every other HMO out there doesn't own their own hospitals and doctors. They contract with large groups. And these large groups are what's happening.

Hughes: Is there more you wish to say?

Burke G.: No, that was it.

Hughes: Okay, very good.

TAPE GUIDE

INTERVIEWS WITH ROBERT GUMBINER, M.D.

INTERVIEW WITH NICK FRANKLIN

INTERVIEW WITH BURKE GUMBINER

EPILOG OF WHAT HAPPENED AFTER I RESIGNED FROM FHP

January 1997

The first book I wrote in 1977 was called *"The HMO, Putting It All Together"*. This epilog of what happened after I resigned from the FHP Board of Directors, could be called *"The HMO, Taking It All Apart"*.

After the FHP Board of Directors meeting at which the Board voted to replace me with Jack Anderson as chairman and to make me chairman emeritus, I realized that I could not work with the likes of Jack Anderson. I surmised that future board meetings would be nothing but continual arguments as I attempted to keep him from destroying the company. Somehow Jack Anderson had seduced two of my Board members, so along with himself and his crony, he was able to control the seven-person board. My attending physicians' advice was to resign since I was on continual antibiotic therapy following my surgery and the continuing stress was impairing my immune system. Therefore I made a decision to resign from the FHP Board, put that behind me, and attempt to get well.

With no opposition, Jack Anderson, who was essentially an insurance executive and investor, began the immediate dismantling of FHP International. His first move was to give Price his marching orders to sell the FHP acute hospitals and sell the FHP sub-acute hospitals. The hospitals were sold in a short time at a discount. Three decades of careful building an integrated health care system was destroyed in three months. The Orange County, Fountain Valley Hospital sold to Memorial Hospital in Long Beach and the Utah Hospital sold to the Paracelsus Hospital Corporation.

As an aside, both of these hospital companies immediately got into trouble. Memorial Hospital in Long Beach ended up in arbitration attempting to get some $280 million back from FHP. They alleged that the number of patients that FHP would put in this hospital and the income generated was misrepresented to them and

that they would lose $280 million over the next ten years. Paracelsus Hospital got into so much financial trouble that they were forced to close three of their other hospitals. The Utah State Health Department shut down the emergency room of the former FHP Hospital for a period of thirty hours because it was undermanned.

The next move Anderson made was to instruct Price to fire most of the FHP senior management. These included Chris Selecky who was in charge of California IPAs, Tim Brady who was in charge of the Riverside Division, and Ryan Trimble who was in charge of the FHP Staff Models in California. He even stooped to closing the art galleries; the one in Long Beach and the new gallery in Utah, saving a measly $300,000 a year and wrecking that P.R. program. Judd Jessup, who had been CEO of TakeCare, was put in charge of the FHP IPA division. On Anderson's marching orders Jessup fired so many FHP senior management people that he ended up having some 24-25 people reporting directly to him. This, of course, was an impossible management situation and Jessup began failing miserably; resigning shortly thereafter.

Anderson's tactics of terminating the senior management were completely in opposition to any good management concept of how to build a company. J. Pierpont Morgan years ago said, "Take away my ships and my factories and my banks but let me keep my management and I will have everything back again." Anderson went exactly the other way. He cut the head off of the organization. There was no direction and no management; he focused only on squeezing every last dollar out of the organization in order to make the bottom line look better short term so he could sell what was left at the highest price.

He then added two more of his cronies and one of Joe Prevratil's to the Board of Directors. This so frightened W.W. Price III, the so-called CEO, that he continued to follow Anderson's direction to keep his job for a few more months and become even more of a cipher.

The next thing that happened, probably at the instigation of Jack Massimino, was to spin off the Staff Model alleging that the Staff Model wasn't making money and therefore it wasn't worth anything. The Staff Model had a gross revenue income of over $400 million a year; it owned or leased over fifty medical centers, fully staffed and equipped. By anybody's calculation who knows anything, this operation was worth over $400 million. The alleged costs against that gross income was suspect for several reasons. Anderson managed to spin it off with the help of the Board of Directors into an independent organization for a projected sale of $60 Million. The idea was that this medical division would then get patients from other HMOs as an independent medical group and be successful. How he thought that a streamlined staff model could be more successful as an old fashioned medical group than a staff model, is beyond me.

In a rather complicated scheme, he arranged to have FHP sustain this Staff Model for about a year by paying an inflated capitation rate for each enrollee. The idea being that the management organization would receive about 10 percent of the value of the medical group, i.e. they would pay $9,600 for 10 percent of this $400 million asset. Then the medical group would buy itself from PacifiCare for $60 million. They would get the $60 million by floating 60 million shares and selling the rights to each share for one dollar a piece. They would use this money then to buy this $400 million asset from PacifiCare for $60 million. At of this writing, it is not known whether this scheme will be successful or not. To make it more confusing, they did a reverse split, dividing the total shares by 21.50, making the shares worth $21.50 each.

Then PacifiCare decided in negotiating rates with this independent medical group that they would not pay the subsidized rates, rather they would pay the regular rates. Therefore this organization became short cash-wise. They have already admitted to losing $9 million last year. The story they give, however, is that this loss is really the result of the losses of the Staff Model beforehand, which of

course is baloney. Probably, they will prepay some 1997 costs in 1996 to make 1997 look better; i.e., "dress it up for sale". This is only one of the items that makes their cost side of the balance sheet suspect.

The other interesting thing, (see the attached newspaper article)*, is that these other HMOs, although they may contract with FHP, are not going to produce enrollees because the competition (the other medical groups and doctors), are going to hang onto their patients and not let them go to this new medical group. Time will tell how this works out.

After selling the hospitals at a discount and everything else that he could get his hands on including the FHP airplane, all of the land that had been acquired and land banked for future development, Anderson set out to sell what was left of FHP to another HMO.

When I left FHP it was a vibrant, successful organization with some $600 million in cash plus land in several states that had been researched and purchased for future expansions, and very little debt. For instance, there were 11 acres purchased off of a freeway in Albuquerque, New Mexico; there were 21 acres off a freeway in Phoenix, Arizona; there were 7 acres in Riverside. My concept had been that you buy land when you can get it, when it is inexpensive, and you hold it and you use it to build your centers and your hospitals when you need it. The fact that you have the land and you have a sign on it, *"Future Home Of ..."* has a tendency to calm down the IPA doctors. Anderson does not understand this, he never understood it and he never understood much about the HMO business.

FHP was then head and shoulders above the other HMOs because of the mixed model concept-- that is, going in with the quick marketing contract IPA and then backing it up for competitive control and capacity where doctors didn't exist with the Staff Model. The Mayo Clinic is now imitating our mixed model in Arizona.

The problem with the contract HMOs is that the organization can only contract with the doctors and hospitals that are there. If the hospitals are not very good,

* Not attached.

that's what you have. If the doctors are not very good, that's what you have. And if the doctors are not there in the adequate numbers of primary care and the specialties are needed, that's what you have; you don't have a managed care system. However, with the mixed model we had the ability to bring in staff models and if we needed two orthopedists we would bring them in, if we needed five general practitioners in a certain area we would bring those in, etc. We had the strength to upgrade the hospitals we used and if they wouldn't do that we would build our own hospitals or threaten to build them. Since FHP had built hospitals they knew we could do this and they would upgrade. This concept was never recognized by Anderson or our other two board members.

You might say that the FHP direction under my guidance of innovation, controlled growth, independent economic viability, development of management staff in depth, quality image and controlled flexibility was totally missing in his concept. He went so far as to tell people directly that he was only interested in maximizing shareholders' income.

At the time of this writing, several things are about to happen. This is January of 1997. PacifiCare has offered to buy what is left of FHP for $35 a share which is $17 in cash and the rest in PacifiCare "B" non-voting shares. Jack Anderson has notified all of the Senior Management of FHP that they are out; they will not be retained. The insurance division is being folded into PacifiCare's insurance division. Jack Anderson and Joe Prevratil have been elected to sit on the PacifiCare Board of Directors. These are the two engineers of the takeover of FHP. This is like injecting yourself with the Ebola virus for PacifiCare. PacifiCare has reorganized their board and enlarged it to twelve where they have six people from UniHealth, which is their parent, and six other people (two of which are these two treacherous connivers from FHP). They have gotten past the FTC where somebody had alleged that they were comering the market on Medicare in San Diego. The SEC seems to not be making any noises and they are now waiting for the DOC (Department of

Corporations) to approve this transaction and consumers groups are complaining.

The spun off medical group Talbert has flown a Red Herring, an S1, where they are attempting to go public so they can try to sell that company for $200 million or more. That's the company that they allegedly bought from FHP/PacifiCare for $96 million because it was worthless. In addition, Anderson and his buddies have the nerve to put themselves on the Board of Talbert and given themselves stock options, every single one of them, with the exception of Burke Gumbiner, who was left off of the Talbert Board, putting Jack Massimino in his place. Obviously they are just playing Burke along for a little cosmetic subterfuge.

Interesting, Anderson has already implied to the FHP Board members how he will take over the PacifiCare Board. First he says it is unfair for the PacifiCare people to have "B" non-voting stock and it should be turned into "A" stock. This will dilute the UniHealth holdings and control. PacifiCare now holds about 40 percent of the stock through UniHealth, their parent company. He also said it is not fair for UniHealth to have six members on the twelve member board when they only own 40 percent of the voting shares. (They will own less than 40 percent of voting shares if he gets rid of the "B" stock and converts it to "A".)

You can see the writing on the wall. He gets the UniHealth block down to about three to four out of the twelve, then he turns a couple more people his way, and he has seven, and he takes over PacifiCare. PacifiCare has done a few things right because they terminated what was left of TakeCare and FHP's Senior Management. But the question is, do they have enough management to run the larger company successfully?

What are my predictions? My predictions are that the spun off medical group Talbert will go bankrupt or they will attempt to sell themselves to somebody else and get sued by shareholders. Another prediction is that PacifiCare will get indigestion when it tries to take over FHP and Anderson will try to take over PacifiCare.

In any event, what ended up as a proud, wonderful company that was FHP,

with the objective to give the most health care to the most people for the least amount of money, projecting quality care in a managed health care system, has been obliterated. This was done by a greedy raider in cooperation with a few stupid board members who acted upon their emotions and greed rather than intellect. To people like Joe Prevratil, who is desperate and at the point of this reading is $6 million in debt in his Queen Mary operation, it is an attempt to save himself and he doesn't care how. To Anderson it is just a game to see how much money he can pile up on top of what he has and how many people he can screw.

Let this be a warning to other people in the HMO field on what can happen to them if they don't keep focusing on their business of providing health care and on succession with strong and determined managers. If they get the wrong people on the board who don't share their vision, and if they don't investigate thoroughly who they are getting in bed with.

This was a classic textbook example of a corporate raid. This is where an outsider gets control of the board, sells off everything that isn't nailed down to make the bottom line look better. They sell the component parts and then the carcass to somebody else, destroying the company.

It wasn't a raid on a company that was faltering, it was a company that was in good financial shape. The only thing that was faltering about it was the leadership by the CEO. There is a lesson to be learned by others and that is, you can't do something halfway and you have to be ruthless and leave like minded people and strong succession in charge.

Attached is advice*for the future for folks that were in my situation, i.e. chairmen caught between governance and management.

*See Appendix E, page 154

RG/ks
1/24/97
WP/EPILOG.FHP

APPENDICES

APPENDIX A

FHP CHRONOLOGY[1]

June 26, 1995	Mass firing begins
June 26, 1995	Hospitals offered for sale
June 26, 1995	Medical group spin-off
June 26, 1995	Special board of directors meeting takes place/restructuring begins
June 22, 1995	Robert Gumbiner resigns
June 15, 1995	Jack Anderson becomes chairman of FHP board of directors, Robert Gumbiner becomes chairman emeritus (special board of directors meeting set for restructure)
May 30, 1995	Robert Gumbiner 2nd prostate surgery
March 9, 1995	Board of directors meeting, Utah (RG unable to attend because of illness)
February 24, 1995	Jack Anderson calls special board meeting
February 8, 1995	Robert Gumbiner prostatic surgery
NOTE:	Something should have been done July-Aug. 1994, i.e. b/d election
June 30, 1994	Richard Rodnick resigns from the board (board reduced from 9 to 8)
June 24, 1994	FHP board of directors enlarged from no less than 7 to no more than 11. Exec: June 28, 1994
June 17, 1994	TakeCare deal closes
October, 1993	Office of the President established (to go for 2 years)

[1]Chronology courtesy of Dr. Gumbiner's office staff.

APPENDIX B

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Long Beach, CA 90803
(310) 433-5459

KCSA CONTACT: Adam I. Friedman
(212) 682-6300

FOR IMMEDIATE RELEASE

LONG BEACH, CA., June 22, 1995 -- In an announcement today, Robert Gumbiner, M.D., resigned his position as Chairman Emeritus and Board member of FHP International Corporation (NASDAQ: FHPC).

Dr. Gumbiner, the founder of the company 30 years ago and formerly Chairman of the Board, commented on the news: "I believe that I have contributed to the growth and success of this enterprise during a long and satisfying career. For three decades my efforts have been directed to creating a first class system to deliver the best in health care, and today it is represented by the FHP Hospitals, physicians and network of the FHP systems.

"I have become convinced that the current direction of the company is not in the best interests of its shareholders, employees or those who are beneficiaries of its services. The recent direction taken by the Board and management lead me to question the wisdom of the company's long-term strategy. Consequently, I have decided to resign my position on the Board of Directors and as Chairman Emeritus rather than be a party to a direction with which I do not concur.

"As a shareholder, I will contribute my opinions and lend my weight to those actions that are in the best interests of the company as I see it. As regards my personal future, I plan to devote myself to my many interests, including my Museum of Latin American Art and a variety of humanitarian and educational projects around the world."

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ROBERT GUMBINER
5456 THE TOLEDO
LONG BEACH, CA 90803
(310) 433-5459
(310) 439-2473 FAX

October 12, 1995

Mr. Michael J. Weinstock
Senior Vice President
FHP International Corporation
9900 Talbert Avenue
Fountain Valley, CA 92708

Dear Mike:

Now that I am recovering from my two recent surgeries and eleven different courses of antibiotics for complications my energy is restored and I have time to contemplate the recent events in FHP.

What has been accomplished by the TakeCare Chairman is a take-over of FHP, just as surely as if he had bought up stock in FHP and acquired control of the Board and Chairmanship by a frontal assault. Instead, this was a back door take-over that achieved the same thing with much less expense, trouble and chance of litigation to him. It is obvious that he has changed the management style of FHP to the management style of TakeCare. No longer does FHP have the in-depth management capability, nor does it have the training of its managers, with the spirit and the attitude they had before. The accent now is on increasing the shareholder equity, particularly the personal wealth of Jack Anderson, not the FHP policy of concern for the patients, the consumers, the staff and the investors.

It is plain to those who have spent a lifetime building FHP, that this organization is not now structured for growth, but instead, it is structured to be dismembered and sold to the highest bidder. The policy is obvious that it is a high risk attempt to dismember the Company, remove all of the marketing and long-term

development programs and instead, increase the profitability on a short-term basis with the hope that it can be sold to profit the take-over artists, particularly Jack Anderson.

I am writing this because of my concern with the FHP Legal Department, particularly the Corporate Attorney. Time and money was spent with outside attorneys attempting to shore up FHP's frontal take-over defenses with poison pills and other devices. However, little, if any time was spent on the problem of a back door take-over. Nor was any warning ever given or advice to the Chairman of the Board regarding this. It seems to me that it is the duty of the Corporate Law Department to be equally cognizant of back door take-overs as they are for frontal assault. There are many things that could have been done in the interim:

The filling of the eleven Board seats immediately before the finalization of the TakeCare acquisition. Instead, nothing was ever heard from the Legal Department as we did a search with a search firm for the ideal Board member and we struggled on with eight Board members. This was a very dangerous situation because there were two TakeCare Board members and all they had to do was to get two members from our Board to side with them and the Board would be unable to do anything, which includes electing new members. We had passed a resolution to increase our Board from nine to eleven so that we had every opportunity to elect a ninth, tenth and eleventh member, which would have protected FHP from what actually happened and that is, turning it into TakeCare; particularly since we paid the TakeCare people a premium for their shares and now they control FHP.

Nor, was there any warning to the Chairman about the activities of Joe Prevratil behind the scenes as he attempted to get rid of Mark Hacken by making a deal with him to pay him off vis a vis a termination agreement on his termination in the position of Co-President in the Office of the President. Corporate Counsel was fully aware of what was happening on the first attempt to take over, testing the waters for the take-over, made by Jack Anderson, when he called a special meeting to get rid of the Office of the President and Mark Hacken two weeks

after I had major surgery. Even then, a good attorney could have advised us to go to arbitration regarding the four to four deadlock and could have advised me of what Joe Prevratil was up to. I did not have the meeting notes of the previous Board of Directors meeting, where perhaps Joe Prevratil was instructed to do this, nor was I fully cognizant of what he was up to, step by step. It seems to me that I should have been kept aware of what was happening here, not simply bushwhacked by a resignation from Hacken a half hour before the Board meeting, which had been negotiated, obviously, the night before.

Particularly disturbing was the fact that I was diligently pursuing new Board members and had narrowed it down to two members; Carl Mottek, the number two man from the Hilton organization and Verle Topham, the head of the utilities company in Utah and had their acceptances to be nominated. I actually had their nominations through the Nominations Committee, 2 to 1, but was being blocked by Board members from bringing those nominations up. I could have been advised by Counsel to convene a special meeting prior to the Board of Directors meeting in which we could have nominated and elected these two directors. If the TakeCare people had manipulated a stone wall, four to four, we could have gone to arbitration on that at that time.

This letter is being written to Counsel to make you aware of the things that could have been done and should have been done to negate this take-over:

1. Increasing the Board of Directors and putting the Board members on immediately

2. Calling a special meeting to do this, if necessary

3. Putting people on the Board who were acceptable, probably former people in the industry, rather than letting the search firm go on forever. I still don't know if the search firm was delayed or road blocked by others during that period.

Anyway, this whole thing is a mess and was a very under-handed deal. I feel that Corporate Counsel should have been responsible for warning the Chairman of the Board of what could happen and what measures should have been taken to avoid it. These measures to avoid a back door take-over are just as important as any measures to avoid a frontal assault. This would make a good case study on what not to do.

Sincerely yours,

Robert Gumbiner

RG:kar
WP/Weinstoc.111

CHRISTINE COTTER / Los Angeles Times

Robert Gumbiner blames FHP International board members for staging a 'backdoor takeover' while he was weak from surgery.

Ill Feelings

FHP's Ousted Founder Says Losing Post Was a Bitter Pill

By BARBARA MARSH
TIMES STAFF WRITER

Robert Gumbiner, the founder and recently deposed chairman of FHP International Corp., isn't taking his ouster lying down.

He talks bitterly about the people who removed him from the managed care company he started 30 years ago. He blames directors for sacking him at a June 15 board meeting when he was still weak after surgery for prostate cancer.

In a wide-ranging interview at his Long Beach home last week, Gumbiner had this advice to corporate leaders: "If you want to be chairman of the board, don't get sick or have surgery or have disloyal board members."

Tan, impeccably casual in a sport shirt, slacks and loafers, Gumbiner says he feels fit again and wishes he'd felt healthy enough a few months ago to launch a proxy battle. "Right now, I'd probably do it," he says. "Sixty days ago, I was feeling pretty bad."

In fact, late last week Gumbiner did show up at the Fountain Valley company's annual meeting, where he publicly criticized the company. After the meeting, he half-jokingly told managers in charge of investor relations and public relations that he had enough trouble in store to make their jobs secure.

Though he wouldn't elaborate, he's already promoting his bitter version of his ouster on several other fronts.

He's flogging a self-published history of FHP. He's considering adding a chapter on his ouster that could be turned into a business-school case study. And he's hired a public relations firm to line up interviews.

So on this day, seated in his circular office studded with artwork from Micronesia, New Guinea and the Pacific Northwest, the 72-year-old physician has his say about his ouster from the company he started.

"This is a classic backdoor takeover by a company we acquired," he says. After Gumbiner was ousted, the board elected the former chairman of TakeCare Inc., the company that FHP acquired, to replace Gumbiner as FHP chairman.

He blames certain directors for mounting a coup when he was in a weakened condition after his surgeries.

The morning of the meeting, he knew he was under fire but still felt he had a chance to keep the chairmanship. He figured he could count on four votes on the eight-member board: Westcott W. Price III, FHP's chief executive; Mark B. Hacken, a former executive; his son, Burke F. Gumbiner, an FHP executive; and himself.

Half an hour before the meeting, however, Gumbiner got a fax saying Hacken had resigned. Gumbiner, entering the meeting with just three votes on his side, didn't feel healthy enough to hold out for a session expected to run up to eight hours. He says he also didn't try to remove the question of his replacement from the agenda.

The board voted him out, 5 to 2. At the last minute, he says,

Please see GUMBINER, D5

GUMBINER: Founder of FHP International Bitter About His Ouster

Continued from D1

even Price deserted him—an act of disloyalty Gumbiner considers especially galling. He asserts he saved Price's job several years ago when the board contemplated firing him.

Price declined to comment.

Directors elected Jack R. Anderson, the former chairman of Take-Care Inc., to replace Gumbiner. Assigned the post of chairman emeritus, Gumbiner went home to bed, he says.

Within a week, he resigned from the board in frustration. "Unfortunately, the people who followed me tried to change the philosophy," he laments.

His diminishing ties to the company now include 150,000 shares of stock and two properties leased to FHP by real estate interests he controls.

Though he wasn't specific about his net worth, he allowed that in 1986, when the company went public, he owned half of its stock, a 5-million-share stake then worth about $60 million.

He's found another project for himself in the ashes of FHP's corporate cutbacks.

For years, FHP operated a senior center and art gallery in a building on Alamitos Boulevard in Long Beach that it leased from a partnership he controls. He's now converting the building into a museum for Latin American art.

On neighboring properties he controls, he recently developed a park and aims to open a restaurant, "Barcelona Brasserie," next month.

At last week's annual meeting, he blamed Joseph F. Prevratil, among other directors, for turning on him. Gumbiner traces troubles with Prevratil back two years, when Gumbiner donated $2 million to the Queen Mary foundation. Gumbiner says he resigned later that year as the foundation's chairman, disappointed with Prevratil's management of the tourist attraction.

'If you want to be chairman of the board, don't get sick or have surgery or have disloyal board members. . . . Right now, I'd probably [fight the ouster]. Sixty days ago, I was feeling pretty bad.'

ROBERT GUMBINER
Ex-chairman of FHP International

Prevratil, denying Gumbiner's account, said he's tired of Gumbiner impugning him. Prevratil expressed the hope that Gumbiner can find satisfaction in his retirement, new wife and considerable wealth, saying, "I only wish the best for him."

But Gumbiner's campaign against the company isn't just personal, it's philosophical. While stock analysts have applauded the company's restructuring, Gumbiner insists that the company structure he set up ensured better care for patients.

He's trying to keep alive his vision of health care delivery by promoting a 408-page tome, "FHP: The Evolution of a Managed Care Health Maintenance Organization; 1955-1992."

Published last year, it traces his life through his interviews with Sally Smith Hughes, a UC Berkeley historian. Sometimes fascinating, often repetitive, it is a colorful take on modern medicine from an industry innovator in managed care.

The book recounts how Gumbiner, raised in Gary, Ind., reluctantly followed his father into medicine. His father paid his college room and board on the condition that Gumbiner would go to medical school, he says.

Though fond of him, Gumbiner says: "He was a typical middle-class conservative doctor. We have plenty of them around today—doctors with very little imagination."

Gumbiner, who found treating patients "boring," gravitated to the business aspects of medicine. Moving to Southern California in 194[9], he first worked as a pediatric resident for the former Orange County Hospital in Santa Ana.

Given to pointing out others' management errors, he got himself fired twice, first as a contagious disease officer for the city of Long Beach and later as a salaried doctor for Ross-Loos, a medical group that pioneered in the area of prepaid medicine.

He opened a solo practice in Lakewood in 1952, started taking management courses a few years later and eventually developed a group practice through which he experimented with prepaid medicine. In 1961, he converted his practice to a nonprofit corporation that became FHP.

Among other innovations, he developed a pilot project for a prepaid Medicaid program in California in 1969 and, 13 years later, got a federal contract to do the same for Medicare recipients.

The company grew according to his personal pursuits, expanding into Utah, where he liked to ski, and Guam, where he went scuba diving.

Now, he's considering adding a chapter on his ouster. He's already drafted up his recollections and figures they'd make a good case study for business students.

If that weren't enough, he's directing a center he developed on the island of Yap to promote the ethnic arts of Micronesia. He's working, too, on plans to add a gym, tennis court and guest room to his 6,000-square-foot home overlooking Alamitos Bay.

Gumbiner does claim one common privilege of retirement, however. He no longer sets his alarm

MY ADVICE TO FOUNDERS & CHAIRMEN WHO WISH TO RETIRE FROM THE DAY TO DAY ACTIVITIES OF THE COMPANY THEY CREATED, PARTICULARLY PUBLIC COMPANIES, BUT ALSO HAVE A DESIRE TO LEAVE A LEGACY IN THE COMPANY HEADED ALONG THE SAME PATH AS THEIR ORIGINAL CONCEPTION

by Robert Gumbiner, M.D.

Founder, Former CEO and Former Chairman of FHP, Inc.

March 1996

In the case of FHP, the original concept was *to provide the most care to the most people for the least amount of money.* Now the concept has changed *to provide the greatest return for the shareholders.*

The problem for the Chairman is one of not having to deal with the day-to-day activity of running the company but at the same time, getting enough information and keeping enough control so the company does not go off in an adverse direction. This is particularly important if you have a company that has been built on controversy and from the contrarian view. In the case of FHP, we started as a group practice, prepayment when the whole medical profession, and in fact, the whole business community considered us to be outliers and evil in some way or another because we were destroying the rapacious medical fee-for-service industry. The biggest breakthrough that FHP made is when they created and took on the MediCal (Medicaid) prepayment and everybody else, including Kaiser, considered this to be a disaster and not the thing to do. Again, steadfast adherence to the benefits and advantages to the company of MediCare risk contracts, i.e. prepayment contracts from the Federal Government for MediCare, was derided by Wall Street and all of the other HMOs, until they finally realized that we were very successful at it.

A lesson to be learned here is that you can not take the advice of others or become intimidated by them! You have to run your company in the best interest of the company, long term and do it with vision. Since Wall Street has no vision, a public company should not take the analysis or fund manager's advice on how to run the company. Their vision extends to the end of the next quarter. One of the problems with FHP was that the people who came after myself had no vision, no courage and no leadership capabilities and were intimidated by Wall Street. They tried to dance to the Wall Street tune instead of taking an objective viewpoint of what was best for the company and the industry in moving forward long term.

The problem for the Chief Executive and the Founder moving up to Chairman is that when he or she does that, since they do it because they do not want to continue going to the office everyday and expending the energy and time it takes to keep the company going in the right direction. Therefore they must have a dedicated staff that reports only to them and to the Board of Directors, and must not depend upon receiving information through the management. New management, by its very nature, may attempt to put their "own paw print" on the company. Some people are just waiting for the CEO to move aside so they can run things differently. Never mind the fact that they don't have the ability or that their ambition exceeds their ability. It's just that they wanted to do it differently even though the way that it has been done has been successful.

The first move is for the Chairman to <u>create an independent staff</u> for the Board of Directors. In other words, he should have a secretary, a legal assistant for governance, and a financial officer who reports only to him and he should have a couple of assistants to get him information.

Most importantly, with any major policy decision such as acquisitions, the Chairman is going to have to come back into the picture and negotiate directly with the Chairman and the CEO of the other organization. He can not leave it up to his own management people. In my case, my management people, especially Bill Price, was so desperate to do something constructive to keep from being fired that he was willing to do anything, including giving away the store. His motivation should have become obvious to me when he opened up negotiations with TakeCare and they speeded up the process behind my back when I was out of the country. Mark Hacken, who I put in to protect the Chairman's interest and the Board's interest, failed to achieve this mostly because he was a frightened and weak personality and secondly because the arch manipulator, Jack Massimino, was in the background putting his "Rasputin" thing on Bill Price. Getting rid of me any way he could was Massimino's main ambition. Instead of recruiting a new CEO, I put a Board Member in the Office of the President to protect my interest and give me information-- this was unsuccessful.

The negotiations for TakeCare opened up with Price and Hacken flying down to Florida to meet with Jack Anderson of TakeCare. That was just a preliminary. But before I knew it, they had invited Jack Anderson up to come to our campus and talk to and view the campus but they didn't let me know when he was coming. He came and went without my knowing it. This should have been my second clue of what they were doing behind my back, that is, attempting to do this deal on their own.

The next thing that happened was there was a flurry of activity and our original price of some $62 a share was rejected and it looked like TakeCare was going to go to United. A mistake made at this time and should have been taken care of at the very beginning when negotiations looked like they were

opening up, was that the Board and the Chairman should have gotten an independent consultant to review this transaction and give us advice of whether this was a reasonable transaction or not. Instead, we were getting all of our information through Bill Price, who was being manipulated by the underwriters, who wanted their 6 percent on the deal. The higher the price, the better for them They kept coming back with a higher price, telling Price and proving to him with the manipulated numbers, that it was a good price and everything was fine and dandy. Everything was not fine and dandy! Price knew that I wasn't too delighted with this deal. I though we were paying too much and acquiring too much debt.

In December of 1994, after we had rejected this deal, I was assured by Price and Hacken that the deal would not go forward and nothing would happen for 60 days. I left the country for three weeks over Christmas. Price then stepped up the activity to try to finalize this while I was gone. They had several meetings with Anderson that I knew nothing of. Then all of a sudden the Board of Directors wanted to close a letter of intent or a preliminary agreement without sufficient investigation and due diligence, in my view. I was out of the country and they even went as far as fly the whole Board to Singapore, to meet with me, to try to make this happen. Another mistake I made at that time was that I should have let the whole Board know by individual letters, that I had been assured that nothing was going to happen and that is why I took a vacation and that I would come back, if necessary, and take over the negotiations.

In any event, I should have pushed Price aside at this point, called up Anderson and told him that I would be doing the negotiating or, better yet, called up the investment bankers and told them that we were not going to pay $82 a share, to get out and don't come back! I should have told Bill Price that

this item, the TakeCare acquisition, would never be on the agenda and stop trying to put it on the agenda and if he did, I was going to fire him. Just let those people know, without bringing it to the Board, that our price was $62 and that was it. I also should have let them know that, since we were buying this company for a high price, their Chairman was not going to be on our Board; their price, our deal.

The problem here is the Chairman and Founder, after thirty years, was pretty well burned out and doesn't really want to get involved in all of this back and forth business. Although he may know that he has to step in at a certain point and take control, in a situation like this where everything is going on behind his back, he is not really in a position to take control because these people are moving it without his knowledge.

It is important here again for the Chairman to have a consultant and to have his own attorney, i.e. meaning the Board and the Chairman has their own attorney and their own consultant, totally independent of the attorneys hired by management or the investment bankers. Needless to say, you wouldn't want an investment banker as your consultant. You would want someone that looked at it independent of their compensation.

Personally, I don't really know what went on behind my back between Price, Hacken and Anderson. I think the whole thing was being moved by the investment bankers and Price was so dumb and desperate, that he would do anything.

Perhaps the fact that I really didn't want to pay any attention to it was because I was tired and bored with the whole thing. I probably subconsciously wanted to get out. I thought possibly that some of the management or Anderson's people would have enough skill to help us build a bigger company.

A major mistake here was in not figuring out what Anderson's goals were.

In other words, he should have been asked the questions point blank, "do you want to grow this company or do want to sell this company?" Most importantly there should have been a private investigative company that investigated Mr. Anderson and Mr. Burdge, i.e. what they had done in the past in acquisitions and management. In the little that I know about Jack Anderson, he had been a Cigna executive and took over the Arizona Health Plan threw out Don Schaller and then proceeded to wreck it. Cigna, at the time he was involved, was the laughing stock of the entire industry. They kept changing executives, doing everything wrong. He also acquired the two sickest companies in the industry, which was Ross Loos and HOMI. I had a couple conversations with him at Board Meetings and he was defending strongly his incompetent activity in those acquisitions, so I should have known the guy was a destroyer, not a builder, and knew nothing about managing anything. That should have been a key. Never put somebody on a Board of Directors who is philosophically different than the person who built the company!

As an aside, what happens gradually in a public company is that you find yourself surrounded by small-minded, short-term thinkers who are "high in the greed poll" and "low on the altruistic scale". This is because many times the people that join public companies join them and work in them mainly to increase their personal wealth and not to achieve something for society or for the industry.

In an acquisition like this; (1) there should be an independent consultant to the Chairman and the Board on the pluses and minuses of the deal, (2) there should be independent legal counsel for the Chairman and the Board, (3) there should be a formal investigation of the background and the history of the people you are dealing with, and (4) you should interview some of the management people of the target company just as if you are hiring them, and

get a background history on the management people and their achievement in the company.

Various key ingredients also should be investigated in the due diligence period such as; are the doctors being paid the correct amount, are they being over-paid and are the rates the correct amount or are they cut-rate. Most importantly, what is the philosophy of the company and the people that are working in it, and the Chairman and the Chief Executive Officer? Is the Chairman really acting as the Chief Officer or do they really have a Chief Executive Officer?

The solution to keeping a company going in the right direction and with the right policy after the founder and CEO retires and becomes Chairman, is to make sure that the people that follow are thinking correctly, i.e. along the lines that made the company great. Don't fall for the idea that the original premises were obsolete and now the company should be changed, and become a follower rather than a leader. The company should make as an objective, recruiting a Chief Executive Officer and Chief Operating Officer that think along the same policy lines: People who are achievement oriented and smart enough to deal with the ambiguous situations that they have to deal with; someone with courage and who can think straight.

Therefore it would be my advice to take your number two man and put him in that slot, which seems the obvious thing to do. But I would make a definite trial period of one year to eighteen months, with firm goals, evaluations of how he selects his staff, how he sets up his tables of organization, what is his vision, how he does marketing, etc. If he doesn't hit the 80 to 90 percentile on this, you simply terminate him, that's all, while you have the power. Then go out and recruit the best person you can, either inside or outside, and give them the one year to eighteen months.

The question then is, do you tell them exactly what goals they have to meet so that they can seem to move toward these goals and try to fool you, but really inside are just waiting to push you aside and let you turn your back so they can put their paw print on things and change things all around? The way they try it is little by little-- they will try one thing and if they get away with that, then they will try another. They become embolden as they go along. Meanwhile, if the Chairman does not pay attention and does not focus on it and wants to just be a traditional Chairman, he is headed for serious trouble.

It shows power to just plain fire a few people every once in a while, particularly the Chief Executive. Otherwise these people that want to get rid of you will just wait until they find you in a weakened state; either through physical or emotional weakness or not focusing because some other thing is happening in your life, and suddenly attack you. Any lightening rod that they can grab onto to help them in this, they will do it.

In my opinion, Jack Anderson in this deal, is simply something that Price could use to further his own ambition. Unfortunately, it got away from him and he wasn't smart enough to deal with Jack Anderson and the Board of Directors.

The question is, even though a Chairman gives himself five years to become Chairman Emeritus and move on, and then spend the next five years just going to the meetings, (maybe he doesn't even want to go to the meetings), how does he know that he is going to leave the company in good hands even though he may leave it in the hands of the third generation? In other words, he may select the number two man and then eighteen months later he finds out the man can't do it, fires him, he recruits another person, eighteen months later to three years out, they have to terminate that person. Then they select another person and the third one doesn't work either.

By that time you should have figured out how to make the third one work and selected people for their altruism, their vision, their social consciousness; the things you really want in a Chief Executive, not their greed index. You can tell by a person that wants a big car and a big house and all of these different trappings of personal wealth that you don't want that person running a health care company.

Another problem, I would advise the Chairman to get a Board of at least fifteen to twenty people; which is more difficult to manipulate than a board of seven or eight. Also, pick people that view things the way he or she does. In our case, we should have had about three or four doctors on the Board that believed in the Staff Model and HMO, with social consciousness. That would have worked. It is very important that, as Board people disappear, we appoint people that are on the right track philosophically; pruned out the people who were on the wrong track philosophically, and not worried about how competent they were as a Board Member. Most of the Board Members we had were not competent anyhow. Joe Prevratil, for instance, was a promoter. Walter Heineman as a bank loan officer. Those people should have been removed when their Board seats came up.

I believe in term limitations; not officially, but unofficially, for your Board Members. Two terms for Outside Board Members and they are out. You might keep the Inside Board Members. Most importantly, I think there should be a number of people who know something about the industry, that sit on your Board. I think equally important is to have some type of group that is not a Board but an Advisory Committee, so you can see how the people think. Then you could bring those people on your Board if necessary. The Insurance Company Board would be a good incubation project for them.

My feeling is that the Board Members should not own stock, they should simply be paid a reasonable amount for their time. If they own stock, even a small amount, they will start short-range thinking.

I believe at least half of the people on the Board should be familiar with the industry, or at least providers; and the other half should be managers. But you should make sure they are really managers, i.e. Chief Executive Officers that were successful, with accent on "successful", and they should be from the service industry.

The question is, how do you keep the Board focused? Do you have people from the industry, people from outside the industry, do you have insiders, do you have outsiders or what do you have?

There must be a way to prevent a radical deviation from policy, such as what has happened with FHP, where they sold off their best assets just for a perceived short-term stock market advantage. A major problem is that a CEO Chairman, after thirty years, gets disinterested and looses his focus and gets burned out. So it is really important that a successor with the right philosophy be selected, and soon.

Succession really is the most important job of that retiring CEO as Chairman. That should be his foremost job, concentrating on that and on nothing else; i.e. evaluating the new CEO. For that purpose it is necessary that he continue to romance his Board of Directors. If they feel he is not focused and disinterested, they will begin power plays. If he is very successful, they may be envious and resentful anyhow. You have to take them places, do things socially with them, talk to them, nurture them. Because if you are egotistical and aloof, they will try to get you one way or the other.

Envy, jealousy, greed and hate-- The Four Horseman ride within the Board of Directors as well as within doctor groups.

Just remember, most of these Board people operate on emotion, again that is why the term limitation is important and is why it is important to have fifteen to twenty Board Members; so they don't all click up to get you for emotional reasons. This is a deviation from my original thoughts of a small group on the Board that you could easily use to make decisions. Some of the Board Members are more decisive than other anyhow.

This was written as advice to people that are in my position because what happen to me could happen to anybody. I wish somebody had given me this advice five years ago.

RG/ks
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ROBERT GUMBINER

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August 22, 1996

FHP Board of Directors

Gentlemen:

Now you have finally done it. FHP, once a proud company, a leader in its field, will disappear!

In the late 1960s, FHP was the first HMO to develop a prepaid Medicare/MediCal program for the State of California, now something that is being promoted throughout the country thirty years later. In 1985, FHP provided the first Medicare Risk Contract in the face of criticism from other HMOs. FHP's Medicare Risk Contract was later copied successfully by Pacificare. Now, most HMOs are offering a similar Risk Contract for Medicare.

The mission of FHP always has been one of innovation and growth with the objective of developing a rational, organized health care delivery system for the patient and the consumer of health care. The objective has never been the amassing of wealth for the shareholders or management personnel at the expense of the consumer or the staff. The development of the most care for the most people for the least amount of money was, in fact, the credo of the whole group practice prepayment, nee HMO, or managed care system. The idea that this industry would exist for the financial benefit of individuals is foreign to the system and not something that was ever a goal.

Managers and Board members who are not familiar with the health care system, in general, let alone the managed care system, are the nemesis of the whole idea of improved health care in the United States.

Now that you have finally destroyed one of the premier HMO organizations serving well the three stake-holders; the consumer, the staff, and the investors, I hope you are satisfied.

Sincerely yours,

Robert Gumbiner

(from San Francisco Chronicle,
February 18, 1997)

PacifiCare
Health Systems

5995 Plaza Drive
Cypress, California 90630-5019
Tel (714) 952-1121

Dear Friends and Neighbors,

I am pleased to announce that the acquisition of FHP International Corporation by PacifiCare Health Systems has been approved. Together, our two companies view this as an extraordinary opportunity to improve the quality of health care coverage for our members and the community.

But even more, we believe we have a unique opportunity to win your trust – something that doesn't seem to be coming easily these days to health care and HMOs.

An Opportunity to Improve Managed Care

We're committed to using our expansion to improve managed care – we see being bigger as an opportunity to be better. I believe that's what our acquisition of FHP is all about. With our greater size and strength, PacifiCare, along with our affiliated physicians and hospitals, plans to prove we are synonymous with quality in health care and personal service.

Member Satisfaction Is Our Greatest Concern

For more than 15 years, we've worked closely with members, doctors and employers to offer what the community is looking for in health care coverage – quality and affordability. We also recognize the importance of providing value and peace of mind.

As we embark on this new era for our company, our nearly 10,000 employees in 14 states and Guam will be working harder than ever to earn and keep the trust of our members and the community. We're developing new services and systems that help our contracting physicians and hospitals improve the quality of care they deliver. And we will continue to build and maintain an environment that supports doctors in doing what they do best – practicing quality medicine.

PacifiCare Welcomes FHP Members

I would like to welcome every FHP member to our two health plans, PacifiCare and Secure Horizons. We want to assure you that there will be no interruption of your health care coverage as we become one company during the year ahead. Please continue to use your health care benefits as you always have – see your same doctors and visit the same pharmacies for prescriptions. And if you have any questions or concerns, we'll be happy to talk to you. Simply call us at the toll-free number on your membership identification card.

We recognize this important moment in our company's history – and the obligations that come with it. On behalf of all the employees at PacifiCare, Secure Horizons, FHP Health Plan and FHP Senior Plan, I'd like to thank you – our valued members and the community – for giving us the opportunity to serve you and to improve the quality of health care coverage for all.

Respectfully,

Alan Hoops
President and CEO
PacifiCare Health Systems

INDEX--Robert Gumbiner, M.D., II

Sally Smith Hughes

Graduated from the University of California, Berkeley, in 1963 with an A.B. degree in zoology, and from the University of California, San Francisco, in 1966 with an M.A. degree in anatomy. She received a Ph.D. degree in the history of medicine from the Royal Postgraduate Medical School, University of London, in 1972.

Postgraduate Research Histologist, the Cardiovascular Research Institute, University of California, San Francisco, 1966-1969; science historian for the History of Science and Technology Program, The Bancroft Library, 1978-1980.

Presently Senior Editor on medical and scientific topics for the Regional Oral History Office, and Research Historian in the Department of History of Health Sciences, University of California, San Francisco. Author of *The Virus: A History of the Concept*, Sally Smith Hughes is currently interviewing in the fields of AIDS and molecular biology/biotechnology.